IRP

Independent Reconfiguration Panel

ADVICE ON

***HEALTH FOR NORTH EAST LONDON* PROPOSALS**

FOR CHANGES TO LOCAL HEALTH SERVICES

Submitted to the Secretary of State for Health

22 July 2011

IRP

Independent Reconfiguration Panel

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RECOMMENDATIONS

- **It is essential to achieve sustained high performance of A&E services and reductions in hospital stays at Queen's Hospital. Clinical leadership is essential, as is concerted action from the wider health community and social care system acting together. This is not only what patients deserve now but also provides the platform for the implementation of future changes to services.**

- **Planned improvements to maternity services, including the creation of alongside midwifery units, should proceed without delay. Policies and facilities for neonatal care should also be reviewed to ensure that they support the needs of families. The implementation should be led and co-ordinated across north east London by the perinatal network, engaging users of services at every stage.**

- **Securing a sustainable healthcare system for north east London, which delivers better outcomes and patient experience within the resources available, requires large scale change. NHS London should ensure that the direction and momentum created by *Health for north east London* is not lost in the emerging management structures for the NHS in north east London as the need to deliver improvements is urgent.**

- **In the context of the urgent need to achieve a sustainable health service for the population of north east London, the Panel agrees that the proposals for A&E, maternity and planned care are more sustainable than the alternatives and offer real benefits in terms of clinical and service quality, including avoidable morbidity and mortality.**

RECOMMENDATIONS

- **Improving patient experience must be at the forefront of the NHS's thinking. NHS Outer North East London and its related clinical commissioning groups must ensure that significantly enhanced public and patient involvement in service design and development is an integral element of the local NHS's approach to changing services.**

- **Further work is required to specify the model of accident, emergency and urgent care that will operate consistently across the hospitals to optimise quality and access for the populations served. The public and users of services, including those with mental health needs, must be fully engaged in that process.**

- **NHS Outer North East London and the related clinical commissioning groups must develop a community and primary care strategy that will reduce the use of acute hospital services. Part of this strategy should consider and clarify the timing and scope of service that should be provided from *polyclinics*.**

- **The future of King George Hospital and the determination of what might best be provided from that location must be the subject of a specific programme of work, led by local commissioners and engaging the public, service users and staff. This should include the further development of the proposal to deliver more high quality planned care at King George Hospital.**

RECOMMENDATIONS

- **The NHS in outer north east London should look at the potential to develop its own transport solutions, in partnership with local authorities where appropriate. There are opportunities to learn from elsewhere and address the needs of specific groups of patients, such as those travelling for planned care, in a way that will enhance outcomes and patient experience.**

- **The Barking, Havering and Redbridge University Hospitals NHS Trust must have a clear plan and actions in place to ensure the safe delivery of existing services at King George Hospital during the transition, engaging users of services and staff in an open and supportive way.**

- **NHS London (and its successor body if required) should ensure that the recommendations above are implemented without delay or omission.**

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.

1.2 On 7 January 2011, Mr Roger Hampson, Chief Executive of the London Borough of Redbridge, wrote on behalf of the council's health scrutiny committee (HSC) to Andrew Lansley, Secretary of State for Health, to refer for his consideration the *Health for north east London* proposals for changes to health services. Two more referrals of the proposals were made on 26 January 2011 by Cllr Dominic Twomey, Chair of the Outer north east London Joint Health Overview and Scrutiny Committee (JHOSC) and on 7 February 2011 by Cllr Liam Smith, Leader of the London Borough of Barking and Dagenham, on behalf of the council's Health and Adult Services Select Committee (HASSC) (Appendix Two).

1.3 The Secretary of State wrote to Dr Peter Barrett, IRP Chair, on 9 February 2011 requesting that the IRP undertake an initial assessment of the referrals in accordance with the agreed protocol for handling contested proposals for reconfiguration of NHS services. NHS London (the strategic health authority – SHA) provided initial assessment information. The IRP set out its initial assessment in a letter to the Secretary of State of 11 March 2011 (Appendix Three).

1.4 A further referral of the proposals was made on 7 March 2011 by Cllr Lynden Thorpe, Chair of the London Borough of Havering Health Overview and Scrutiny Committee (HOSC) (Appendix Two).

1.5 The Secretary of State wrote to Dr Peter Barrett on 17 March 2011 asking the IRP to undertake a full review of the *Health for north east London* proposals and to consider the suitability of the referral from Havering HOSC for inclusion within the review (Appendix Four). The IRP provided an initial assessment of the Havering HOSC

referral on 18 March 2011 advising that it would be suitable for inclusion within the review and agreeing to the proposed terms of reference (Appendix Three). The Panel was asked to advise by 22 July 2011:

a. Whether it is of the opinion that the proposals for change will enable the provision of safe, sustainable and accessible services under the "*Health for north east London*" proposals and if not, why not;
b. On any other observations the panel may wish to make in relation to the changes; and
c. On how to proceed in the best interests of local people in light of a. and b. above and taking into account the issues raised by London Borough of Redbridge in their letters of 30 December 2010 and 7 January 2011 respectively, the outer north east London Joint Health Overview and Scrutiny Committee in their letter of 26 January 2011, the London Borough of Barking and Dagenham in their letter of 7 February 2011, and London Borough of Havering in their letter of 7 March 2011.

OUR PROCESS

How we approached the task

2.1 NHS London, Barking and Dagenham, Havering, Waltham Forest and Redbridge primary care trusts (PCTs) were asked to provide the Panel with relevant documentation and to arrange site visits, meetings and interviews with interested parties. The *Health for north east London* team (H4NEL), on behalf of the PCTs carried out these tasks.

2.2 The JHOSC, Barking and Dagenham, Havering, Redbridge and Waltham Forest HOSCs[1] were also invited to submit documentation and suggest other parties to be included in meetings and interviews. The Panel identified additional stakeholders to interview.

2.3 An IRP press release, advising that the Panel would be undertaking a review, was issued on the 18 March 2011 (Appendix Five). The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 4 April 2011 informing them of our involvement (Appendix Six). The letter invited people who felt that they had new evidence to offer, or who felt that their views had not been heard adequately during the formal consultation process, to contact the Panel.

2.4 A sub-group of the full IRP carried out the review. It consisted of nine Panel members - Peter Barrett who chaired the sub-group, Nick Coleman, Nick Naftalin, Ray Powles, Jane Hawdon, Gina Tiller, Linda Pepper, Ailsa Claire and John Parkes. Other Panel members attended on a number of days during the review. Sub-group members visited The Royal London, Queen's, King George, Homerton, Newham and Whipps Cross hospitals. Eleven days of oral evidence taking were held. Informal *drop-in* sessions for staff took place at the Queen's and King George hospital sites on the evenings of 6 and 14 June 2011. Details of the sites visited and people seen during sessions and are included in Appendix Seven. The IRP Secretariat accompanied members throughout.

[1] Except where referred to directly, scrutiny committees will be referred to generically as HOSCs in this report.

2.5 All local members of parliament were invited to submit views and offered the opportunity to meet the Panel. Meetings were held with Lee Scott (Ilford North) on 17 May 2011, Mike Gapes (Ilford South) and Jon Cruddas (Barking and Rainham) on 24 May 2011, Margaret Hodge (Barking), Angela Watkinson (Hornchurch and Upminster) and Andrew Rosindell (Romford) on 20 June 2011.

2.6 A list of all the written evidence received – from the SHA, PCTs, NHS trusts, JHOSC, individual HOSCs, MPs and all other interested parties is contained in Appendix Eight. The Panel considers that the documentation received, together with the information obtained in meetings, provides a fair representation of the views from all perspectives.

2.7 Throughout our consideration of these proposals, the Panel's focus has been the needs of patients, their relatives, public and staff taking into account the issues of safe, sustainable and accessible services for local people as set out in the IRPs general terms of reference.

2.8 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views. Particular thanks are due to the staff of the London boroughs involved for the use of their buildings and facilities, and the H4NEL team for arranging the large number of site visits and assisting with overall arrangements.

2.9 The advice contained in this report represents the unanimous views of the Chair and members of the IRP.

THE CONTEXT

A brief overview

3.1 The services that are the subject of the proposals and review by the IRP are provided by five north east London acute trusts - namely Barts and The London NHS Trust, Barking, Havering and Redbridge University NHS Trust (BHRUT - Queen's and King George hospitals), Whipps Cross University Hospitals NHS Trust, Homerton University Hospital NHS Foundation Trust and Newham University Hospital NHS Trust.

3.2 Their services are commissioned mainly by the following PCTs - Barking and Dagenham, Havering, Redbridge, Waltham Forest, City and Hackney, Newham and Tower Hamlets. Services are also commissioned by PCTs in Essex, particularly NHS West Essex. As a result of changes in the way the NHS is operating, PCTs have formed into 'clusters'. There are two clusters in north east London - NHS Outer North East London (NHS ONEL) and NHS East London and the City (NHS ELC). NHS ONEL is a partnership of the following PCTs - NHS Barking and Dagenham, NHS Havering, NHS Redbridge and NHS Waltham Forest. NHS ELC is a partnership of the following PCTs - NHS City and Hackney, NHS Newham and NHS Tower Hamlets. Each cluster has established a 'cluster board' that is accountable for commissioning health services for north east London during the transition. In respect of *Health for north east London* decision making, these boards replace the inner and outer north east London Joint Committees of PCTs (JCPCTs) which have to date taken decisions relating to the proposals for change subject to this review.

3.3 Subject to the passage of the current Health and Social Care Bill, PCTs will be replaced by clinical commissioning groups (CCG). The emerging commissioning consortia in north east London are set out below:

- United Medical Consortium (within the borough of Barking & Dagenham)
- Barking & Dagenham Quality Healthcare Clinical Commissioning Consortium
- Havering First Consortium
- Havering Premier Consortium

- Redbridge Consortia (single consortium with four ward-based *polysystems*)
- Waltham Forest Federated Consortium (three separate consortia operating under a federated governance structure)
- ELIC GP Consortia (within the borough of City and Hackney)
- KLEAR GP Consortia (within the borough of City and Hackney)
- Newham Health Partnership
- Newham Commissioning Group
- Tower Hamlets GP consortia

3.4 Work to consider the future configuration of health services in outer north east London began in August 2006 with the *Fit for the Future* programme. The following year, in July 2007, NHS London published *A Framework for Action*, Prof. Lord Darzi's ten-year vision of how the provision of healthcare in London should evolve. Extensive public and clinical engagement was undertaken and following public consultation, in June 2008, the (pan-London) JCPCTs agreed the proposals.

3.5 In December 2008, the *Health for north east London* programme was initiated. Building on the principles established and consulted on in *A Framework for Action,* the programme brought together all NHS organisations in north east London (that is, inner and outer north east London PCTs and trusts) to develop a clinically-led programme of change to improve health and healthcare across the whole area.

3.6 Between January and November 2009, the clinical case for change, options for delivering change, decision-making criteria and proposals for consultation were developed and refined through clinical working groups and the engagement of the public and stakeholders, including the relevant scrutiny committees. Pre-consultation engagement with the public began in April 2009 and ran until August 2009. Four workshop events were held in April 2009 to identify non-financial decision-making criteria for the option appraisal process. 119 people took part in these workshops. Of these 119, 72 were members of the public and 47 were healthcare professionals. A series of public meetings were held in June 2009 to share information about the *Health*

for north east London programme and test support for the principles set out in *Healthcare for London*. On 2 June 2009, an event was held for NHS organisations and stakeholders, including Local Involvement Networks (LINks), to share information about possible options for change. A public involvement event was held on 18 August 2009 to determine the system for weighting the decision-making criteria used for short-listing options. 35 people attended this event and around two thirds were public or voluntary sector organisation representatives. PCTs held a number of awareness raising events in October 2009.

3.7 In line with Department of Health guidance, these processes and their outputs were subject to National Clinical Advisory Team (NCAT) and Office of Government Commerce (OGC) Gateway review in June and July 2009 before a pre-consultation business case was developed and signed off by NHS London on 29 November 2009.

3.8 The NHS organisations in north east London set out six key reasons in the pre-consultation business case for making significant changes in the way healthcare is delivered in the sector:

- *Improve the health of the people in north east London and ensure healthcare services are meeting public expectations*
- *Address the additional demand on service due to population growth*
- *To respond to the fact that more care can be delivered in community settings than ever before and patients benefit from care closer to home*
- *Address workforce challenges which prevent delivery of the best quality care and optimal patient outcomes*
- *To adopt new models of care and best practice which can deliver better outcomes for patients*
- *To make best use of taxpayers' money*

The case for change was stated to be primarily clinically driven. However, it was noted that projections showed that hospital costs were increasing faster than the tariff prices that hospitals receive so that the future financial situation was potentially worsening.

3.9 A formal consultation, *Delivering high-quality hospital health services for the people of north east London* was launched on 30 November 2009 to run for 14 weeks to 8 March 2010 – an additional two weeks being incorporated into the consultation period to allow for the Christmas holidays. The consultation sought views on a number of proposals:

- That The Royal London Hospital, Whitechapel, and Queen's Hospital be developed as major acute hospitals for north east London by consolidating the sector's complex vascular surgery, urgent surgery and complex surgery on children onto the two sites. This builds on the decision, taken following *The Shape of Things to Come* public consultation, to designate both these sites as hyper acute stroke units and for The Royal London to be designated as a major trauma centre, all due to be fully operational from April 2010.
- That three of the other four acute hospital sites – the Homerton, Newham and Whipps Cross – be developed with co-located obstetrics and A&E departments.
- That A&E, critical care and maternity services be moved from King George Hospital and the hospital be developed to provide 24/7 primary care-led urgent care, extended hours GP and community services, outpatient appointments, minor procedures, diagnostic services and a planned surgical centre.

3.10 In January 2010, Redbridge HSC resolved to refer the consultation to the Secretary of State for Health citing its strong opposition to proposals to downgrade services at King George Hospital. Initial assessment advice was sought from the IRP, which advised that it was in the best interests of local health services for the consultation process to run its full course.

3.11 In February 2010, following discussion with local LINks and other stakeholders, the PCTs agreed to extend the consultation deadline by two weeks to 22 March 2010, bringing the total consultation period to 16 weeks.

3.12 Around 57,000 consultation documents were distributed along with 5,000 in alternative formats. A 'compact' version of the consultation document was published, providing an overview of the issues being consulted upon and this was translated into nine languages

and made available in audio, Braille and large print. In addition, an easy to read version was produced specifically for audiences with learning disabilities. 25 roadshows were held, attended by some 7,200 people, with at least two roadshows in each PCT area, including one at each hospital. Over 300 meetings, events and focus groups were held. Further, each PCT held meetings with under-represented groups. In all, 57 meetings took place. Local LINks were actively involved in the consultation planning and delivery, arranged over 20 consultation meetings and provided formal responses to the consultation. The inner and outer north east London People's Platforms, which were set up to enhance public engagement in the development of the proposals, also submitted formal responses.

3.13 Staff were informed about the consultation and encouraged to provide their views. As a result, 29 per cent of responses to the consultation questionnaire came from NHS staff.

3.14 Presentations were made to council bodies, HOSCs were briefed and councillors were invited to meetings arranged by NHS organisations. Inner and outer north east London JHOSCs[2] carried out a three-month review of the proposals. Both JHOSCs submitted formal responses to the consultation.

3.15 In all, more than 3,200 responses were received. All responses to the consultation were independently analysed by Ipsos MORI. An Integrated Impact Assessment was commissioned from independent experts. The assessment was overseen by an independently chaired Steering Group, an interim report was produced in March 2010, with the final report available in May 2010.

3.16 In May 2010, an event was held with local clinicians to discuss the consultation feedback. This was followed by a stakeholder briefing event for public representatives and other stakeholders, including the HOSCs on 8 July 2010. The JCPCTs formally

[2] Two JHOSCs were formed to consider the proposals. Unless stated otherwise, JHOSC in this report refers to the Outer north east London JHOSC

considered the results of the consultation on 13 July 2010. They requested further work be done to review the clinical proposals in the context of the feedback received from the consultation and taking into account the four new tests for reconfiguration, as set out in the *Revision to the Operating Framework 2010/11* published on 21 June 2010. This stated that reconfiguration proposals must demonstrate:

- Support from GP Commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base; and
- Consistency with current and prospective patient choice

3.17 The NHS London Board agreed an assurance framework to discharge its new obligations in respect of the four tests in October 2010 and established a Review Panel to consider the *Health for north east London* proposals in the context of these tests. The Board also delegated decision-making to the Chief Executive of NHS London, who concluded that the four tests had been met on 14 December 2010.

3.18 During July to December 2010, work continued to develop revised proposals in the light of the consultation feedback and prepare the decision making business case. Around 60 meetings were held, primarily with clinical staff and GPs, but also with local authorities and public representatives. The revised proposals were formally considered by the inner and outer London JHOSCs, HOSCs and local authority cabinets in October and November 2010. A number of stakeholders, including the JHOSC, provided formal views on the revised proposals during this period. Detailed outputs from this work were presented to the JCPCT at its final decision making meeting on the 15 December 2010.

3.19 At the meeting on 15 December 2010, the JCPCTs agreed to the revised proposals subject to assurances requested by GPs and local stakeholders. The assurances requested were:

- *Sustained improvement in A&E performance, patient experience and bed capacity at Queen's Hospital before services are transferred*
- *Sustained improvements to maternity capacity, quality and patient experience at Queen's and Whipps Cross hospitals before changes are implemented*

- *Assurances that by centralizing emergency medical and surgical services and obstetrics there will be improved senior clinical cover at Queen's Hospital*
- *Demonstrable progress in reducing admission rates and lengths of stay to ensure sufficient bed capacity at Queen's Hospital before services are transferred*
- *Assurance that the necessary capacity is available at other hospitals affected by the changes*
- *A clear model for the Urgent Care Centres (UCC)*
- *A&E services are not transferred from King George Hospital until the UCC is working effectively*
- *A clear communications strategy for patients regarding access to urgent care*
- *A clear workforce strategy and assurance of workforce skills and capability ahead of service transfers, particularly maternity services*
- *Assurance regarding capacity in primary and community services to manage urgent care needs of residents*
- *Improved access to diagnostics and timely results for primary care*
- *Assurance that transport options have been considered and support provided where possible*
- *Further development of the care pathway for mental health patients presenting in A&E and those requiring a mental health assessment*
- *A commitment to King George Hospital as a viable health campus*
- *Assurance that there will be full engagement of clinicians, social services, patients and the public as implementation progresses*

3.20 The inner and outer north east London JCPCTs had previously agreed changes to complex vascular surgery, in October and November 2010. Decisions taken were communicated to stakeholders between December 2010 and January 2011. The revised proposals were:

Urgent and emergency care

- *A&E, medical and surgical inpatient care and critical care to be provided at five hospitals in north east London – Queen's, Whipps Cross, The Royal London, Homerton and Newham*

- *Complex vascular surgery to be provided at Barts and the London and Queen's Hospital*
- *Urgent care to be enhanced at all hospitals with better and quicker access to tests, consultants and specialist advice. Recommended co-location with GP out of hours services*

Maternity and Newborn care

- *Five maternity campuses to be developed, aligned to the five trusts in north east London, providing comprehensive maternity and newborn care including obstetric and midwifery-led delivery care and neonatal care (The Royal London, Homerton, Newham, Whipps Cross, and Queen's hospitals)*
- *A choice of birth setting to be offered (obstetric led care, co-located and free standing midwifery-led birthing centres and home births) with a target of a minimum of 40 per cent of all births in midwifery-led settings*
- *King George Hospital to continue to provide antenatal and postnatal care, including maternity day care – fetal heart rate monitoring, ultrasound and triage*
- *In addition, more antenatal care to be provided closer to home in children's centres and local health facilities*

Planned Care

- *Planned surgery to move from Queen's Hospital to King George Hospital except where there are benefits in co-locating services or on the basis of clinical need*

Children's Care

Provide more specialist care for children at The Royal London and Queen's hospitals and improve the services available at other hospitals. More children to be cared for locally than originally proposed through:

- *Early senior assessment to reduce admission and minimize unnecessary lengths of stay*
- *Stronger links to be developed between hospital and community-based services*
- *Children requiring inpatient care to be under the care of a designated paediatrician, even those admitted to an adult ward*
- *Where safe and appropriate, surgery on children over six months old to take place at*

any hospital

- *Transfer of children under six months old requiring surgery to The Royal London Hospital, except for minor ophthalmic surgery (any hospital), and neonates already at the Homerton Hospital*
- *Transfer of children requiring specialist care to The Royal London Hospital or the improved services at Queen's Hospital or another centre, for example Great Ormond Street Hospital (as now)*

King George Hospital

Services at King George Hospital to include:

- *24/7 urgent care and GP services*
- *Short stay assessment and treatment for adults and children*
- *Diagnostics*
- *Antenatal and post natal maternity day care*
- *Child health centre*
- *Outpatient services*
- *Cancer day care*
- *Renal dialysis*
- *Inpatient and day care rehabilitation services*
- *Planned care centre including planned surgery*

3.21 The London Borough of Redbridge HSC met on 4 January 2011 and decided to refer the proposals to the Secretary of State. Referral was made on 7 January 2011. The key components of the Redbridge HSC referral were:

- *concerns over the content and timing of the consultation on the Health for north east London revised proposals; and*
- *that the revised proposals are not in the interests of the health service in the London Borough of Redbridge*

3.22 On 18 January 2011, the JHOSC, which included membership from Redbridge HSC, met and decided to refer the proposals to the Secretary of State. Members present from

the London Borough of Waltham Forest voted against the referral. A referral letter was sent on 26 January 2011. The JHOSC's letter states that the reasons for referral are summarised in the report of the JHOSC, March 2010, and the Joint Committee's letter of 6 December 2010 to the H4NEL Programme Director commenting on the revised proposals. The key concerns set out in these documents are:

- *that demographic growth has not been fully taken into account*
- *timing of the development of services to compensate for the closure of A&E and inpatient maternity services at King George Hospital*
- *the level of GP support for the proposals*
- *quality concerns at Queen's Hospital*
- *capacity at Queen's, Newham and Whipps Cross hospitals*
- *management of transition arrangements*
- *the needs of patients with mental health concerns who present at A&E*
- *travel issues*
- *the impact on social care*
- *whether the proposals are in the best interests of the local population*

3.23 On 26 January 2011, the Health and Adult Services Select Committee of Barking and Dagenham Council met and decided to refer the proposals to the Secretary of State for Health. A letter of referral was sent on 7 February 2011. The reason for the referral was stated to be concerns that Queen's Hospital will not be able to cope with additional demand for A&E services and that the changes are not in the interests of local residents.

3.24 On 1 March 2011, Havering HOSC decided unanimously to refer the proposals to the Secretary of State for Health. The reasons for referral were:

- capacity of both Queen's Hospital A&E and maternity service to cope with additional demands
- concerns about quality at Queen's Hospital
- that demographic growth has not been fully taken into account

3.25 The Secretary of State for Health asked the IRP for an initial assessment of the referrals from Redbridge HSC, Barking and Dagenham Council and JHOSC on 9 February 2011. Following receipt of that advice, the Secretary of State requested on 17 March 2011 that the IRP undertake a full review and consider the suitability of the referral from Havering HOSC for inclusion within the review. The IRP provided an initial assessment of the Havering HOSC referral on 18 March 2011 advising that it would be suitable for inclusion within the review and agreeing to the terms of reference for the review.

INFORMATION

What we found

4.1 The Panel received a substantial volume of written and oral evidence, which has been of great assistance in enabling it to reach its conclusions and subsequent recommendations. We are most grateful to those people who took the trouble to give evidence and for the care taken by those who made presentations, especially members of the public. The Panel considers that the documentation received, together with the information obtained during oral evidence gathering sessions and other meetings, provides a fair representation of the views from a variety of perspectives. The evidence submitted is summarised below under headings that emerged during the review. The tables and map have been taken from documentation submitted to the IRP by the NHS.

4.2 Population Profile

4.2.1 The population of the seven PCTs in north east London taken from Office of National Statistics (ONS) data is almost 1.6 million. However, population estimates vary depending on the source of the information. The number of patients registered with GPs in the seven boroughs is substantially higher at 1.8 million. Some sections of the population are highly transient and it is widely acknowledged that there are sections of the community who are not counted in official statistics nor registered on GP patient lists.

Table 1 **North East London Populations 2010-11**

PCT Name	Funded Population	GP Registrations
Barking and Dagenham PCT	165,817	182,300
City and Hackney Teaching PCT	221,789	272,900
Havering PCT	240,040	251,600
Newham PCT	252,964	333,300
Redbridge PCT	247,161	264,500
Tower Hamlets PCT	225,616	242,600
Waltham Forest PCT	229,033	270,700
Total	**1,582,421**	**1,817,900**

Source: H4NEL IRP Template

4.2.2 Overall, the age profile of north east London is younger than the London average, 10.4 per cent over 65 compared to 10.9 per cent and substantially lower than the England average of 15.1 per cent. There are, however, significant differences between the boroughs. For example, Newham has one of the youngest age profiles in the country and 68 per cent of the population are from Black and Minority Ethnic (BAME) groups. Havering has a higher percentage of older people than the London average and the rate of growth of the older population is higher. Barking and Dagenham has a relatively young population profile and around 80 per cent of the population are white. Redbridge is becoming increasingly ethnically diverse. There was a 32 per cent increase in the proportion of BAME population between 2001 and 2009, which is much higher than the average increase for London (18 per cent), and outer London (27 per cent). In 2009, it was estimated that nearly 50 per cent of the population were from BAME groups. The population of north east London has been growing quickly over the last decade and this increase is predicted to continue. The population is highly diverse with over 100 languages being spoken in some boroughs.

Table 2 **Forecast Population Growth 2010 to 2017**

PCT Name	Growth %	Growth
Barking and Dagenham PCT	12.4	20,542
City and Hackney Teaching PCT	6.8	15,121
Havering PCT	5.7	13,612
Newham PCT	12.6	31,984
Redbridge PCT	4.5	11,190
Tower Hamlets PCT	14.8	33,473
Waltham Forest PCT	2.9	6,735
Total		**132,656**

Source: H4NEL IRP Template

4.2.3 The birth rate in some of the north east London boroughs is the highest in the UK and is continuing to rise each year as shown over page.

Table 3 **Actual and Forecast Births 2001-02 to 2016-17**

PCT Name	2001/02 Actual	2009/10 Actual	2016/17 Forecast
Barking and Dagenham PCT	2,407	3,624	4,876
City & Hackney Teaching PCT	4,148	4,574	4,997
Havering PCT	2,382	2,697	3,071
Newham PCT	4,805	6,003	7,242
Redbridge PCT	3,110	4,253	5,282
Tower Hamlets PCT	3,646	4,337	4,871
Waltham Forest PCT	3,510	4,533	5,620
Total	**24,008**	**30,021**	**35,958**

Source: H4NEL IRP template

4.2.4 Overall, there is poorer health and lower life expectancy than the rest of London. There are a higher number of premature deaths from a range of diseases such as cancer, and cardiovascular disease, with a significant variation between the communities in outer north east London. There are high rates for infant death and mortality. There are increasing rates of long-term conditions such as diabetes and chronic obstructive pulmonary disease.

4.2.5 There are high levels of deprivation, which is particularly marked in Hackney, Tower Hamlets, Newham, Barking and Dagenham and Waltham Forest.

Table 4 **Index of Multiple Deprivation by Local Authority. Rank out of 354 English Local Authorities**

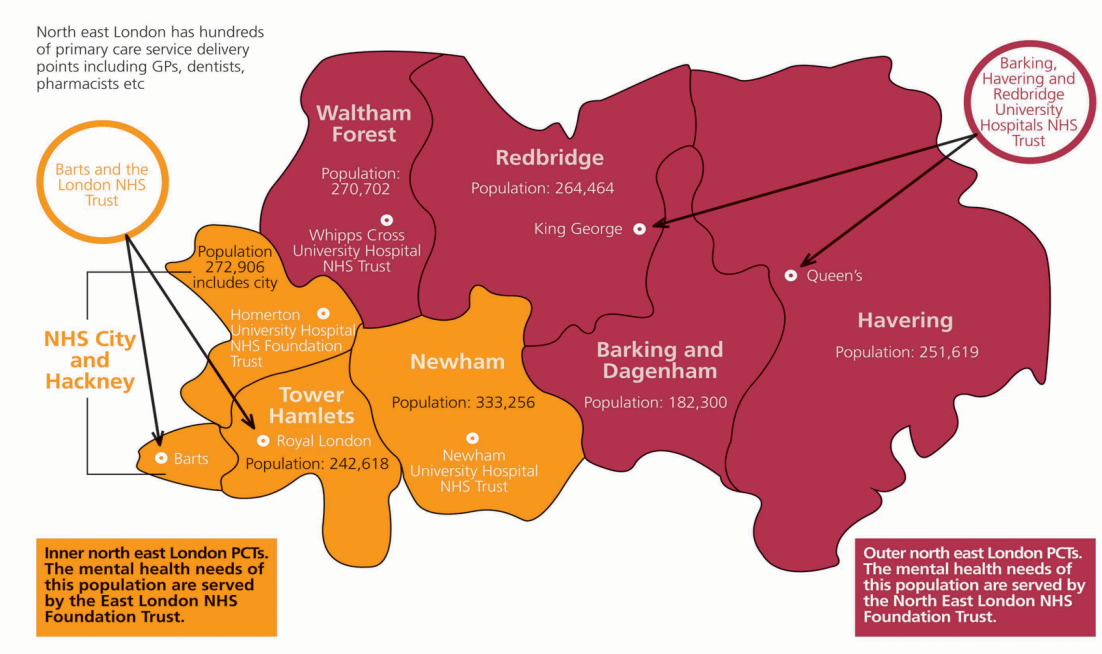
Local Authority	Rank of Average Rank
Barking and Dagenham	11
Redbridge	121
Havering	197
Waltham Forest	15
Hackney	2
Tower Hamlets	3
Newham	6

Source: H4NEL

4.3 Geography, access and transport

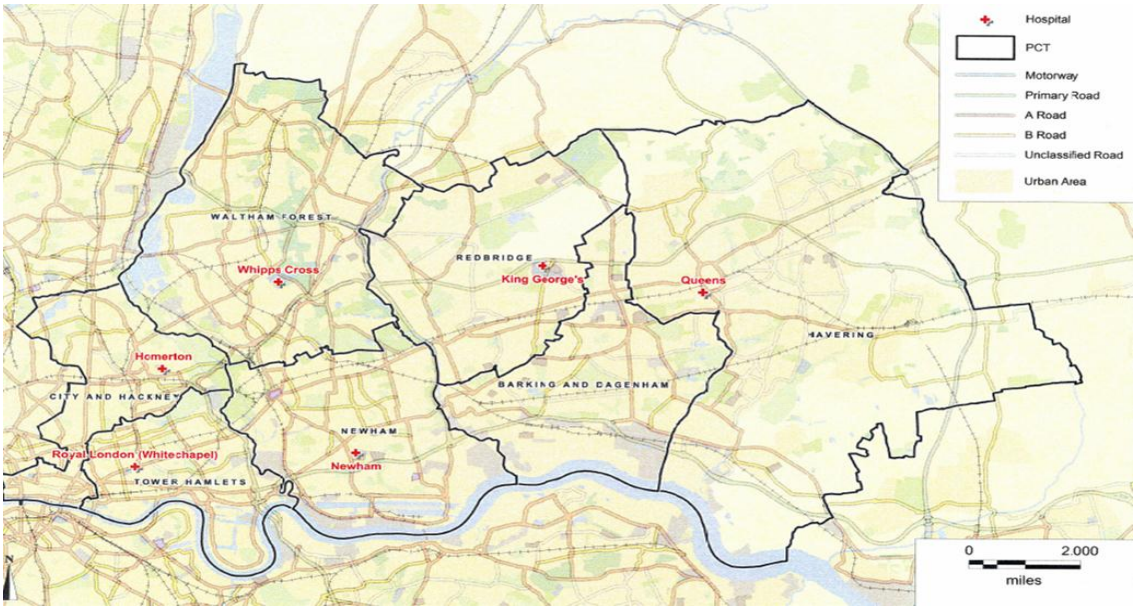
4.3.1 There are six hospitals in outer north east London - The Royal London, Homerton, Newham, Whipps Cross, King George and Queen's. Locations are shown in Map One.

Map One Hospital sites in north east London



4.3.2 Major road access is shown in Map Two. The area is well served by trains, buses, underground and the docklands light railway. There are major trunk routes cutting across the area. In general, road and rail routes radiate out east-west from central London and north-south journeys are more difficult. Road congestion can be severe on some major roads at certain times of the week.

Map Two Transport links in north east London



4.4 Service Profile and Estates

4.4.1 *Acute services*

The six hospitals in north east London currently provide a full range of local acute services including A&E, emergency admission, obstetrics and planned care. King George and Queen's hospitals are both managed by BHRUT. The Royal London Hospital is part of the Barts and the London Trust. The Homerton, Whipps Cross and Newham hospitals are all separate NHS trusts. Both Queen's and The Royal London hospitals are centres for cancer, neurosciences, cardiac care and specialist vascular surgery. The Royal London Hospital is a major trauma centre. Patients in north east London suffering stroke or heart attack are taken to specialist centres at either Queens or The Royal London hospitals for stroke and the London Chest Hospital for heart attack. Planned activity for these units for 2010-11 is shown in table 5 below:

Table 5 **East London Hospitals: Planned Activity 2010-11**

	A&E Attendees	Urgent Care Attendees	Sub-total A&E and Urgent Care	Elective Spells	Non-elective Spells	Births	Out-pt Activity
King George Hospital	65,205	43,287	108,492	18,586	24,760	2,289	130,332
Queen's Hospital	94,201	49,511	143,711	28,449	40,979	7,113	413,056
BHRUT (sub-total)	**159,406**	**92,798**	**252,203**	**47,035**	**65,739**	**9,402**	**543,388**
Barts & The London Trust	107,985	42,950	150,645	39,006	44,828	4,585	486,313
Homerton Hospital	69,296	34,086	103,382	14,707	22,048	4,830	196,322
Newham Hospital	73,087	47,097	120,184	14,745	28,916	5,214	211,830
Whipps Cross Hospital	111,183	38,127	149,310	38,247	32,731	5320	264,159

Source: H4NEL IRP Template

4.4.2 Within BHRUT, Queen's Hospital is a private finance initiative (PFI) hospital opened in the last five years. King George Hospital is approximately 25 years old and the accommodation is generally of a good standard. Together, BHRUT has 1,181 beds[3] across the two hospital sites.

4.4.3 Whipps Cross Hospital has a relatively old estate with medical and surgical inpatient wards being housed in nightingale-type wards. Overall, there are 606 beds. The design of the wards and a lack of isolation rooms has been held partly responsible for an outbreak of norovirus in 2009/10 that caused the hospital to be shut for several weeks. The hospital also does not meet the standards for single-sex accommodation. A business case to improve A&E accommodation has been approved and a business case to improve ward accommodation is under consideration.

4.4.4 Newham Hospital has 367 beds and most of the hospital is 30 years old but a new PFI extension was opened five years ago. The accommodation is of a good standard.

4.4.5 Homerton Hospital is approximately 30 years old, has 405 beds and the accommodation is of a good standard. The site is shared with the North East London Mental Health Trust and the mental health unit on this site will be undergoing major redevelopment in 2012.

4.4.6 The Royal London Hospital has buildings dating from 1757 and 1890 to new modern facilities. The site is undergoing major redevelopment with a PFI scheme nearing completion. This will enable major improvements to be made such as a shift in the percentage of single rooms from 17 to 50 per cent. Further redevelopments are planned for the Frontage and Prescott Street areas of the hospital in 2011/12. The site is very constrained.

[3] All bed figures quoted are taken from Form KH03 - the collection of data to monitor available and occupied beds open overnight that are consultant led – published by Department of Health 19 May 2011

4.4.7 *Community Services*

The majority of community health services in outer north east London are currently provided by ONEL Community Services and are expected to transfer to North East London Foundation Trust in 2011. The other main NHS providers of community health services in north east London are:

- North East London Foundation Trust
- East London Foundation Trust
- Homerton Hospital Foundation Trust
- Barts and The London NHS Trust

The quality of the community services estate across north east London is variable with some facilities in need of updating, refurbishment or replacement. Barking Community Hospital has undergone a substantial two-year redevelopment programme and has recently been re-opened, providing mental health and sexual health services. A range of outpatient services are planned to commence in August 2011 with further services planned to come on stream in 2012 including a walk in centre, antenatal and postnatal care and a midwife-led birthing unit.

4.4.8 *Primary Care Services*

There are 338 GP practices in north east London, 194 in outer and 144 in inner north east London. Of these, 84 practices in outer and 19 in inner north east London are single-handed GPs. The quality and suitability of premises is variable and some are of poor quality, particularly in Barking and Dagenham. There are a number of polyclinics operating in north east London:

- Loxford Polyclinic in Redbridge
- Haroldwood Polyclinic in Havering
- Oliver Road Polyclinic in Waltham Forest
- Vicarage Lane Medical Centre in Newham
- Barkantine Health and Wellbeing Centre in Tower Hamlets

At Barking Community Hospital there is also now an Urgent Care and Primary Care Centre that will become fully operational in 2012.

4.4.9 Further developments are due to come on stream during 2011 and 2012:

- in Tower Hamlets, Newby Place in early 2012 and St Andrews later in 2012
- in City and Hackney, Kenworthy Road Health Centre in September 2011
- in Newham, E20 Health Centre in Stratford following the Olympics

A primary care and *polysystems* strategy for outer north east London is currently in development. Plans for health centres in East Dagenham and Waltham Forest and polyclinics in Redbridge and Havering are under consideration.

4.4.10 *The Care Quality Commission*

The Health and Social Care Act 2008 brought in a new system of regulation for healthcare and adult social care providers in England. All providers are now required to register with the Care Quality Commission (CQC) to achieve a licence to operate and must adhere to new Essential Standards of Quality and Safety. Where the standards are not met, the CQC can impose conditions and take enforcement action. All the trusts in north east London are registered without conditions, with the exception of BHRUT, which was registered in April 2010, with eight conditions relating to five essential standards of quality and safety. The conditions applied to both Queen's and King George hospitals and were as follows:

- All staff employed who require resuscitation training must receive training in resuscitation techniques
- All staff to receive an appraisal within the 12 month period
- The employment of sufficient staff with appropriate skills to meet the patient's needs
- All midwives who have contact with children must receive child protection training
- All nurse mandatory training to be completed
- Patients are not admitted to treatment rooms, clinical diagnostic areas and theatre recovery
- Discharge planning must commence on admission and care plans monitored and updated for the duration of their stay.
- Processes must be in place to assess and record pressure damage in patient's care plans

4.4.11 All but one of these conditions was removed following improvements by the Trust. However, the CQC subsequently carried out two reviews:

- a review of maternity services following which the CQC demanded urgent improvements
- a review of A&E services which is due to be published in July 2011

4.4.12 On 29 June 2011, the CQC announced it would be undertaking a full investigation into the care provided by BHRUT. The investigation will review the care that patients receive from the Trust across emergency care, elective care and maternity services.

4.5 Financial Profile

4.5.1 The turnover of the five acute trusts is set out below. BHRUT has reported a deficit for a number of years. The cumulative deficit, as measured against the Trust's break-even duty is just under £150 million as at 31 March 2011. Newham Hospital NHS Trust reported a deficit in 2010/11 but all other trusts are now in financial balance. Only the Homerton is a Foundation Trust. The transition to foundation trust status for the other trusts is still to be determined and is likely to involve at least one merger.

Table 6 **Financial profile 2010/11**

Trust	Turnover 2010/11	Surplus / (Deficit) 2010/11
Barking, Havering & Redbridge Hospitals Trust	£407m	-£32.9m
Barts and the London Trust	£716.3m	£6.01m
Homerton Hospital	£188.2m	£1.9m (excluding impairments)
Newham Hospital	£166.7m	-0.7m
Whipps Cross Hospital	£243.8m	£0.4m (excluding impairments)

Source: H4NEL

4.5.2 All of the PCTs broke even or achieved a surplus in 2010/11.

Table 7 **Reported PCT year end position**

PCT	20010/11 Revenue Surplus
Barking and Dagenham PCT	£0.6m
City and Hackney Teaching PCT	£6.5m
Havering PCT	£0.9m
Newham PCT	£7.5m
Redbridge PCT	£6.2m
Tower Hamlets PCT	£6.8m
Waltham Forest PCT	£0.0m

Source: H4NEL

4.6 The need for change

4.6.1 The contested proposals for A&E, maternity and elective care that arose from the consultation *Delivering high-quality hospital health services for the people of north east London* are part of a much broader approach to securing a sustainable health care system for the area. The consultation document stated that the reasons for change were:

- To address below average life expectancy and above average rates of death from cancer, cardiovascular disease, diabetes and other conditions
- To improve patient satisfaction, hospital performance and quality of services
- To improve staff retention and recruitment especially in maternity, children's services and A&E
- To address population growth
- To respond to increasing population diversity
- To address the impact of deprivation on health and life expectancy

Specific reasons for change were set out in relation to the following aspects of services:

- Providing care and advice closer to home, to improve ill-health prevention, care for people with long-term conditions and accessibility of services
- Providing complex care on fewer sites, to improve safety, quality and patient satisfaction
- Separating planned operations from emergency services, to reduce disruption, infection rates and improve efficiency
- Emergency and critical care, to increase senior doctor cover and speed up diagnosis and treatment

- Maternity care, to extend choice for mothers to have home births or go to midwife-led birthing units and improve senior doctor cover for women who have been assessed as higher risk.

The consultation document states "*clinicians have said that things must change and that 'no change' is not an option for north east London".*

4.6.2 The H4NEL team told the Panel that the proposals for change were based on a review of best practice and national and international evidence of effectiveness. The proposals for change fell into three groups:

- Improvements to the quality and consistency of care
- Opportunities to improve care by stronger joint working across primary and secondary care
- Improvements that could only be achieved by consolidating services

4.6.3 The Panel heard strong and consistent support for the proposals from clinicians, managers, commissioners and GP leaders from the developing commissioning consortia across outer north east London. The Panel was impressed with the level of collective commitment and convergence of clinical opinion about the direction for future services not only from those closely involved locally but also those with an interest from relevant clinical networks.

4.6.4 It was evident that the development of the proposals had been clinically-led. The Panel also heard evidence that the case for change was consistent with the strategic priorities of NHS London.

4.6.5 The Panel reviewed the pre-consultation business case, decision-making business case and 'four test' documentation. The case for change had been subject to peer and Royal College review and NCAT assessment. The Panel noted that the drivers for change were consistent with best practice and evidence of clinical effectiveness and had been the basis for similar changes across the country and had a high level of local clinical support.

4.6.6 There was agreement from the JHOSC that there was a case for change and clinical evidence to support centralisation. People acknowledged that they had seen benefits through centralisation of stroke and trauma services locally. The borough HOSCs and councillors voiced differing views regarding the strength of the case for change. Barking and Dagenham, Havering and Waltham Forest HOSCs were generally supportive of the principles, as was the Essex member of the JHOSC. Redbridge HSC, however, did not believe that there is any solid evidence to support the view that the proposals to centralise the services will lead to real improvements in patient care.

4.6.7 The primary concern from the JHOSC, HOSCs and councillors who gave evidence to the Panel was not the absence of a case for change, but rather the lack of credibility and viability of the proposals in the current circumstances, where Queen's Hospital was seen as 'failing' on safety, quality and capacity and when patient experience and confidence was low.

4.6.8 The Panel heard from staff who said that they understood the case for change but had concerns about capacity and the impact on King George Hospital of the current uncertainty and in the period before the changes were implemented if they went ahead.

4.6.9 The Panel heard a variety of views from members of the public and community groups about the need for change. Many people accept the need for change in principle, but their acceptance was completely overshadowed by a belief that the proposals are not tenable given the concerns about the quality of services at Queen's Hospital. In addition, they have significant concerns about capacity at Queen's Hospital to respond to the proposed increase in A&E attendances, and consequent admissions, and increased births in the maternity unit.

4.6.10 Not everyone agreed in principle with the need for change. The Panel heard from a number of people who wished to see the configuration of maternity, A&E and planned care services remain as at present, or for a different hospital in north east London to lose A&E and maternity services. Some people felt that financial issues rather than clinical quality concerns had driven the proposals and some that they were driven by the need to

"sweat the assets" of PFI hospitals, or difficulties of making changes to PFI hospitals. The Panel also heard that there was a perception that the proposals were too heavily weighted to addressing medical workforce issues and had failed to balance this adequately with patients' needs and experience.

4.6.11 Those councillors and individuals who were aligned to the Save King George Campaign Group told the Panel that they did not accept the case for change, believed the planning process and assumptions to be flawed and did not feel the proposals were the right way forward. There was a belief that the improvements in outcomes associated with increased senior medical presence had been overstated.

4.7 Emergency and Urgent Care

4.7.1 The consultation document sets out that the proposals for changes to A&E are intended to address issues of safety and quality of care, lead to quicker and better diagnosis, reduce waiting times in A&E and improve outcomes and patient experience. The proposal is to consolidate services by reducing from six to five sites with A&E departments, with the A&E at King George Hospital being removed and an expanded and enhanced 24/7 urgent care centre provided on that site. All sites would have an enhanced UCC operating 24/7.

4.7.2 The Panel heard from the trusts and NHS ONEL that current A&E departments are not functioning as well as the best in the country, based on a review of best practice and evidence of effectiveness. The Panel received information that Queen's Hospital performance on the 4-hour standard was the second worst in the England in the first quarter of 2011/12. The Panel received independent evidence that compared to the best performers nationally, the trusts in outer north east London are still some way off having implemented known best practice in urgent and emergency care. There are, however, indications of improvement - for example, Whipps Cross Hospital is now in the upper quartile in England for performance against the 4-hour standard that was in place until 2010/11 and achieved a 14 per cent improvement in length of stay in 2010/11. Newham Hospital has one of the shortest lengths of stay on the emergency pathway in London.

4.7.3 The CQC told the Panel that it had recently conducted a review of the A&E department at Queen's Hospital due to concerns about quality and safety.

4.7.4 The Panel heard evidence that the College of Emergency Medicine recommends 24/7 senior clinical cover in A&E departments as being the key mechanism to ensure the highest standards of emergency care. The Panel was told by the clinicians involved in the clinical working groups that achieving this staffing level across the six hospital sites in north east London is not possible due to national workforce constraints and shortages. Similar quality and workforce issues apply to the availability and seniority of medical staff cover for acute medical and surgical admission units, emergency surgery, critical care, maternity and paediatric services associated with each A&E department.

4.7.5 The trusts in north east London told the Panel that because of these staffing constraints, improving A&E services and care along all emergency care pathways relies on consolidation of services from six to five A&E departments. Staff are spread too thinly at present.

4.7.6 A&E departments in outer north east London have high attendance rates relative to the population numbers and due to the pressures on the existing departments people spend a long time waiting for treatment and those with the most serious injuries or illnesses are not seen quickly enough.

4.7.7 The Panel heard that the development of a consistent, enhanced 24/7 urgent care model across north east London, as the 'front door' to urgent and emergency care, at each hospital is also essential to enable:

- A&E teams to focus on patients with the most serious conditions and thereby improve outcomes and reduce mortality
- Improve access, continuity and quality of care for minor injuries and illnesses

In addition, effective functioning of all emergency pathways relies upon having acute assessment units behind every A&E with consultant presence, rapid access to diagnostics and a 'flow' through the hospital.

4.7.8 The Panel heard from clinicians that they considered that the case for change to consolidate A&E services is even more pressing now given the increasingly challenging environment at Queen's Hospital, growing workforce pressures and increasing financial challenges.

4.7.9 The trusts and NHS ONEL told the Panel that they are already jointly implementing these changes as far as they are able in the present circumstances. There was a will to work collaboratively across the healthcare system and, in particular, to support Queen's Hospital to improve.

4.7.10 The Panel heard that at present there is not a clear and agreed model for the urgent care centres although the expectation is that they will be modelled closely on the UCC currently operating at Whipps Cross Hospital.

4.7.11 NHS ONEL and commissioning consortia leads told the Panel that in addition to the planned 24/7 UCCs at each of the six hospitals in outer north east London they were committed to further development of urgent care services in primary care settings and to enhanced working with hospital services to improve urgent care pathways. The planned 111 telephone service, intended to make it simpler to access the right immediate care service, will soon be piloted in outer north east London and was seen as key to helping people to navigate the urgent care pathway in future.

4.7.12 The Panel heard from BHRUT that the main challenges it faces in terms of the quality of A&E services at Queen's Hospital currently are:

- Lack of a fully functioning UCC 24/7
- An over-reliance on locum, bank and agency staff due to recruitment challenges
- Insufficient senior medical cover in A&E for immediate assessment
- Improving acute assessment pathways through the hospital
- The physical constraints of the current design of the A&E department

The Panel was told that, at present, the Trust is in a *vicious circle* due to the challenges it faces with recruitment and retention which impacts on quality. Consolidation of A&E

services would create opportunities for the Trust to move towards 24/7 consultant cover thus improving clinical quality and allowing greater supervision of junior staff and increased training opportunities. Together, these would improve the Trust's ability to recruit and retain staff. This would address one of the major quality issues and risks in A&E at Queen's Hospital. The opportunity to improve senior medical cover as a result on the consolidation of services would be a major step in achieving a sustainable position.

4.7.13 BHRUT reported to the Panel that it had made some recent progress on a number of these issues. Full staffing had been achieved in A&E nursing, offers were out to fill all middle grade posts and adverts were out for eight A&E consultant posts with a strong field of candidates coming forward. Very recent performance on 4-hour waits had been around 96-97 per cent. BHRUT told the Panel that it recognised the challenge now was to sustain these improvements.

4.7.14 The Panel members visited the A&E departments at all of the trusts in outer north east London and visited the A&E department at Queen's Hospital on three occasions. On two occasions when the Panel visited, the A&E department was relatively quiet while on the other visit it was very busy. The Panel found the department to be cramped, particularly the waiting area where all walking adult patients arrived, and found the layout confusing. Staff reported that they felt under great pressure and junior medical staff did not feel the current situation was conducive to good training and development. The Panel's perception was of a service under pressure, a fragile medical staffing position and a lack of strong clinical leadership within the A&E department.

4.7.15 The Panel heard about the plans to expand the department, ahead of any changes to services at King George Hospital. The Panel viewed the plans and looked at the proposed areas for expansion on site. The intention is to expand the UCC by relocating it to an adjacent outpatient area (with the outpatient services moving to a community setting), expand the A&E into the current UCC area and increase the number of resuscitation bays. The Panel heard that the business case for the planned expansion of

the UCC was expected to be submitted to NHS London by September 2011 and work on site could potentially be completed by March 2012, subject to funding.

4.7.16 The Panel visited the A&E department at King George Hospital and met nursing staff who Members found to be very impressive and very passionate about the unit. The Panel formed the impression that the nursing leadership there is of a high standard. The Panel was also impressed with the clinical leadership from GPs it met in the urgent care centre although it observed that the facilities needed to be improved.

4.7.17 The Panel received evidence that an audit conducted in 2010 of the patients seen in the A&E department at King George Hospital had demonstrated that approximately 50 per cent are minor cases or patients suitable to be seen in the current UCC. With the upgraded and expanded UCC that is proposed, it is expected that a target of 65 per cent of current patients being seen in the new UCC is readily achievable. The forecast number who will be displaced to other hospitals based on 1010/11 activity levels are an average of 79 per day to Queen's Hospital, 30 to Whipps Cross Hospital and 20 to Newham Hospital.

4.7.18 A new A&E, UCC and emergency admissions unit to provide additional capacity is under construction at Whipps Cross Hospital and is due to open by December 2012. The business case for an expanded A&E and UCC at Newham Hospital is currently going through the approval process.

4.7.19 The Panel received a substantial volume of written and oral evidence from members of the public, LINks and community groups expressing concern regarding the proposed changes to A&E services. It also heard evidence from the JHOSC and Redbridge, Waltham Forest, and Barking and Dagenham HOSCs and councillors from the London Borough of Havering.

4.7.20 The most frequently voiced reason for opposition to the proposed change was the view that Queen's Hospital is not coping with current demand and quality of care is currently poor. This concern had been present since the proposals were consulted upon, albeit it

was one of the reasons cited for the need for change, but has been heightened by the issues identified by the CQC and the announcement by the CQC during the review of its intention to undertake a full investigation of the services provided by BHRUT. People told the Panel that they had lost confidence in Queen's Hospital and did not want to go there for A&E services. People found it hard to contemplate how Queen's Hospital could take on additional demand and provide a high quality service. Concern was expressed that rather than an improvement in quality of services it would be a retrograde step.

4.7.21 Some people believed that the closure of A&E at King George Hospital might lead to a *domino* effect of other services being withdrawn and the hospital being closed.

4.7.22 Concern was expressed about the difficulty of accessing alternative A&E facilities. There were many requests for retention of the A&E department at King George Hospital.

4.7.23 The Panel was told that there was a great deal of confusion amongst members of the public about what an UCC was and what services it offered. The Panel was told that the proposals lacked detail about how needs would be met in different settings and how this fits together from the perspective of patients and families. People did not understand the statements made by those supporting the proposals that around 80 per cent of people who go to an A&E do not need to go there. There was concern that people might go to the wrong place or that journeys would be much longer and that there might be fatalities as a consequence. A number of people raised the issue of the highly diverse local population and the particular challenges for people who speak other languages than English, to navigate the system. The Panel heard that for many people the case for closure of the A&E department and its replacement with an UCC had not been made in the consultation document.

4.7.24 The Panel heard evidence that a high proportion of people who go to A&E also have mental health needs and there were concerns that the proposals had failed to address these needs even though it was raised before and during the consultation.

4.7.25 One of the concerns that was consistently voiced to the Panel was that the proposals were fundamentally dependent upon enhanced community and primary care services, which were not yet in place. A number of councillors raised concerns about the impact of the proposals on the demands for social care and that the NHS was withdrawing community services that supported reducing A&E attendances, such as walk-in centres and extended opening hours of GP practices. They also stated that the NHS had reneged on promised developments in the community services that underpinned the proposals, including delay in commissioning services at Barking Community Hospital and investment in further polyclinics.

4.7.26 The Panel received evidence from the H4NEL team that the planning assumptions used were conservative and did not rely on developments in primary and community services nor assume increased social care provision.

4.8 Maternity Services

4.8.1 The consultation document states that the birth rate in north east London is high and is expected to continue rising so there is a need to increase the capacity of local maternity services. It also records that, in 2007, a Healthcare Commission review highlighted weaknesses in maternity services in the area. While improvements have been made there is still more to do. The aim of the proposals is to extend choice for mothers to give birth in the setting they prefer, be that a home birth or birth in a midwife-led birthing unit or a hospital obstetric unit, subject to the level of risk associated with their pregnancy, and improve senior doctor cover for women who have been assessed as higher risk.

4.8.2 The Panel heard evidence that the four Royal Colleges of Obstetricians and Gynaecologists, Midwives, Anaesthetists and Paediatrics and Child Health recommend that maternity units with over 5,000 births per year should aim for round-the-clock (168 hours) senior doctor presence in order to reduce mortality. Senior doctor presence in the maternity units in north east London is significantly below this target with the current ranges being between 40 and 98 hours. As with A&E services, there are national

workforce constraints and workforce shortages which mean that the challenge of achieving this target is much reduced if services are consolidated onto five sites rather than the current six.

4.8.3 The NHS trusts and NHS ONEL told the Panel that maternity services across north east London needed to improve. Clinical outcomes are not as good as they should be. For example, there are higher than average levels of caesareans and higher than average low birthweight babies. Infant mortality, although improving, needs further work. They had listened to women who had told them that they wanted greater choice in the location and type of maternity service available to them and that currently their experience of maternity services is not always good and they do not feel they have meaningful choices available to them.

4.8.4 The Panel heard from clinicians who set out the model of five maternity campuses, each providing a comprehensive service focused on normalised care pathways, offering a choice of birth settings (obstetric unit and alongside midwifery-led unit) supported by choices for home births or births in free-standing midwifery-led units (MLU). They outlined plans for a greater range of antenatal and postnatal services to be available closer to where women live. The aim, over time, is for 40 per cent of all births to be in alongside midwifery-led units, freestanding MLUs or at home.

4.8.5 The Panel heard evidence from Whipps Cross NHS Trust that they were already delivering 16 per cent of all births in the alongside midwifery-led unit and planned to increase this to 20 per cent over the next year.

4.8.6 The clinicians told the Panel that they fully supported the proposals as the best way to improve the quality of maternity services in north east London and that they considered that the case for change to consolidate maternity services is even more pressing now given the urgent need to improve quality at Queen's Hospital.

4.8.7 The Perinatal Network indicated that it was very supportive of the proposals and considered that the plans were in place for the necessary neonatal facilities associated with the consolidation and anticipated workload flows.

4.8.8 The Panel heard evidence of improvements being made to the current services. At Whipps Cross Hospital, the level of consultant obstetrician cover has been doubled in the last eighteen months and there has been an increase in consultant cover to 72 hours per week. In addition, the midwives have been formed into eight new teams, with one of these teams focused on home births and another supporting vulnerable women. The Trust is making greater efforts to engage women especially those from BAME groups to improve the quality of experience. At Newham Hospital, the midwifery vacancy rate has been reduced from 20 per cent a year ago to 5 per cent. The Panel visited the maternity units at each of the hospitals in outer north east London.

4.8.9 The Panel was told that achieving the recommended level of consultant cover was problematic as it costs more than the current national tariff pays for maternity care.

4.8.10 The Panel heard evidence from the CQC regarding concerns about quality at Queen's Hospital and the action the CQC was taking to ensure improvements were made.

4.8.11 The Panel heard from BHRUT about the improvements that were being made and were planned at Queen's Hospital to improve the quality of maternity services. Currently the unit has 90 hours of consultant cover per week. The Trust told the Panel that the key areas where improvements were being made were:

- Implementing a new triage system
- Funding and recruiting additional midwives to achieve a staffing ratio of 1:29
- Recruiting additional nurses and support staff
- Achieving a ratio of 1:1 midwife care in labour for more than 95 per cent of women
- Improving medical staffing including senior anaesthetic presence
- Improving systems for engagement and feedback from women and families
- Developing an alongside midwifery-led unit

The Panel heard that sixty midwives have been recruited and around forty are already in post. The new triage system has been implemented to ensure women are assessed immediately on arrival in the unit and new standards have been set and are being monitored to ensure that all high-risk women are seen by a consultant within one hour of arriving in the unit. The Trust told the Panel that the highest priority now is the development of the alongside midwifery-led unit.

4.8.12 The Panel visited the maternity unit and the adjacent vacant ward that has been identified for conversion to the alongside midwifery-led unit and looked at the plans. The unit was busy when the Panel visited. The Panel saw the new triage area and good facilities and equipment for low risk midwife-led births. The Panel members observed the discharge area was cramped and in need of improvement. Some delivery rooms are internal without any natural light, which the Panel felt was not conducive to maternal well-being. The number and range of facilities for fathers or families to stay was limited. The size of the neonatal unit, combined with a very harsh medicalised environment was not sensitive to mothers and families needs to bond with their babies, which the Panel felt should be better addressed irrespective of the need for medical intervention. There was not sufficient space around each cot for mothers to relax near their baby.

4.8.13 The maternity unit at King George Hospital is a low-risk maternity unit and there are currently 40 hours of consultant cover per week provided by the consultants covering the ante-natal and post-natal clinics. The number of deliveries at King George Hospital had dropped to a low of 1,300 but the Trust has taken action to increase this, particularly given the pressure on Queen's Hospital, and it was now operating at a level consistent with around 2,500 births per year. The Trust told the Panel that there are risks that staff become de-skilled if the number of births gets too low and there are challenges with maintaining approval for doctors in training on which the unit relies.

4.8.14 The Panel visited the maternity unit at King George Hospital. The unit was very quiet when the Panel visited. Staff were very committed to the unit and the service that it provided and would like to see it undertaking a higher number of deliveries and remain

open although they understood the issues for quality and safety around the level of consultant cover. Staff reported that they work across both the maternity units on rotation and that the unit at Queen's Hospital is under a great deal of pressure. The Panel found the physical facilities to be very good.

4.8.15 The Panel heard that the H4NEL team had looked at the option of maintaining an MLU on the King George site but that the favoured option was for an MLU in Barking Hospital. The H4NEL team told the Panel that the volume of births in the area of King George and Barking Hospital was not sufficient to support two MLUs. Barking Hospital was the preferred option as it was closer to an area of population with high levels of deprivation and there was a clear differentiation for women that this was a MLU. It was felt that an MLU in King George Hospital might give women a false impression about the level of support if there were complications with the delivery.

4.8.16 NHS ONEL had recently appointed a dedicated commissioner for maternity services who was formerly a midwife so that there was now an expert focus on maternity commissioning. One of the early tasks for this post-holder would be developing the specification for the MLU to be provided at Barking Hospital followed by a formal procurement process.

4.8.17 The NHS Trusts and NHS ONEL told the Panel that they were aware of concerns about the potential impact on the quality of experience and care associated with very large maternity units. They were of the view that the campus model, of obstetric units with separate, but along-side, midwife-led delivery units staffed by separate teams would avoid the risks of the quality of care and experience being compromised by the size of the units. The Panel received evidence from the Royal College of Midwives and Royal College of Obstetrics and Gynaecologists that they support the campus model.

4.8.18 The following pattern of births across the maternity units in outer north east London is expected by 2016/17 if the proposals are implemented:

Table 8 **Planned pattern of births by 2016/17**

Trust	Home/FMLU births	AMLU	Obstetric-led Unit
Queen's	150	2,500	5,500
Whipps Cross	150	2,700	5,400
Newham	150	2,870	5,740

Source: H4NEL

This pattern of activity relies on women selecting the maternity unit closest to where they live. This is a change from the current flows for maternity services. The plans anticipate more women from Redbridge will choose to go to Whipps Cross Hospital. If these flows do not change, there is the potential for the number of obstetric-led deliveries at Queen's Hospital to increase to around 9,000 and those at Whipps Cross Hospital and Newham Hospital to reduce accordingly.

4.8.19 The Panel heard from NHS ONEL and GP commissioners that they intended to address the current barriers to choice that women currently experience. This was reported to be due in part to lack of information available to women at the time of booking but also due to midwives from each maternity unit being attached to specific GP surgeries. As a result, women are automatically booked for delivery at the maternity unit at which the midwife linked to the woman's GP practice works. It was felt that this was inappropriately limiting choice and distorting flows.

4.8.20 The National Childbirth Trust told the Panel that they supported the proposals for change and that they believed that women would prefer to have their babies as close to home as possible and would generally choose the maternity unit closest to home if they were not having a home birth.

4.8.21 The Panel heard that the commissioners and clinicians in north east London intended to develop a maternity network that would ensure that capacity and demand were managed across the area and quality was safeguarded.

4.8.22 The business case for the alongside midwifery-led unit at Queen's Hospital will go to the Trust Board in early August and then to NHS London. The capital cost of the development is in the region of £3m. If agreed, the new unit could be operational by April 2012. NHS London told the Panel that it was supportive of the business case.

4.8.23 There are plans to expand and improve the facilities in the maternity units at Newham Hospital and Whipps Cross Hospital. At Newham Hospital, the first phase of the development is underway and will be fully open in February 2012 bringing capacity up to around 7,500 births. A further £10m development is planned to bring capacity up to 9,000 births. At Whipps Cross Hospital, six additional delivery rooms are under construction and there are plans for an expansion of capacity as part of a wider development plan. Discussions are underway with NHS London to bring forward the elements of this plan that relate to maternity services.

4.8.24 The Panel received a substantial volume of written and oral evidence from members of the public, LINks and community groups expressing concern regarding the proposed changes. It also heard evidence from the JHOSC and Redbridge, Waltham Forest, and Barking and Dagenham HOSCs and councillors from the London Borough of Havering.

4.8.25 As with the proposals for changes to A&E services, the most frequently voiced reason for opposition to the proposed change was the view that Queen's Hospital is not coping with current demand and quality of care is currently poor. This concern was even higher for maternity services than for A&E as a result of the publicity around CQC concerns and reports of maternal deaths. People told the Panel that women had lost confidence in Queen's Hospital and did not want to go there to have their babies if they had any other choice. Some people told the Panel that women were very fearful about the idea of having to go to Queen's Hospital to have their babies. The Panel was presented with a number of personal narratives about poor experiences at Queen's Hospital. The Panel heard from some councillors that they found it hard to get information about improvements underway or planned at the hospital.

4.8.26 Almost without exception, HOSCs, councillors, JHOSC members, LINks, community groups and individuals told the Panel that they found it hard to contemplate how Queen's Hospital could take on additional births from King George Hospital, have capacity to cope with population growth and provide a high quality service. Concern was expressed that, rather than an improvement in quality of services, it would be a retrograde step. Virtually all of those who gave evidence to the Panel in opposition to the proposals voiced concerns about the creating of a *baby factory* at Queen's Hospital. People believed that the number of births at that unit would be in the region of 10-12,000 per year. It was brought to the Panel's attention that the largest units in the UK are currently delivering around 8,000 births per annum and so if this was the case it would be breaking new ground in the UK. Some people thought it would be bigger than any single maternity unit in Europe.

4.8.27 Members of the save King George Hospital Campaign Group told the Panel that they had a number of concerns about the basis on which the decisions had been made. They were of the opinion that the evidence of the link to improved outcomes of increased consultant cover had been overstated in the case for change, that the proposals would not achieve 168 hours of consultant cover unless a number of other maternity units were closed in north east London and they were concerned that there was, as yet, no clinical evidence about the outcomes for mothers and babies from MLUs. They pointed out that there are examples of obstetric-led units separate from A&E - most notably Liverpool Women's Hospital and that the case for co-location had been overstated.

4.8.28 The Panel heard that people felt that, even if the principle of consolidation was correct, the proposals lacked credibility, given the current performance and poor reputation of Queen's Hospital.

4.8.29 A number of HOSC members and councillors believed the assumptions about population growth and future births were underestimated, not least due to continued high levels of migration into the boroughs in north east London.

4.8.30 Councillors and community groups from Essex told the Panel they felt that the needs of their residents and the impact of the proposals on them had not been taken into account. The Panel was told about current patients flows from Essex to King George Hospital for whom Queen's Hospital would not be an accessible option. There were concerns about the impact of the changes on hospitals in Essex and whether these had been taken into account.

4.8.31 LINks and community groups told the Panel that Queen's Hospital was difficult to get to for the people affected by the proposals and some people felt this would stop women attending for ante-natal check ups. A number of HOSCs, Councillors and LINks commented that Queen's Hospital was not well located to serve the areas with growing populations and that these localities were much closer to King George Hospital. The Panel was told that most of the births displaced from King George Hospital would be to mothers living in the west, in Barking and Dagenham and yet Queen's Hospital is in the east. This caused concern to some people who told the Panel that they were concerned that Whipps Cross Hospital would not be able to cope with the demand.

4.8.32 The Panel heard evidence from Redbridge HSC, LINks and individuals that they considered that the planning assumption of 40 per cent of births taking place in alongside midwifery-led units, MLUs or at home was over-optimistic, particularly given the current rate of under 10 per cent. In their view, for many women, due to poor home circumstances and deprivation a home birth would not be feasible. The Panel was told that many women want to have, and indeed expect, a doctor to be present at the birth. The Panel heard that there were cultural expectations amongst the population that meant that more women than planned would want to have their babies in the obstetric-led unit. There were concerns that women would be denied choices as there was not sufficient capacity in the obstetric-led units. The Panel was told that many women present late in pregnancy due to cultural issues or lack of knowledge about how and when to access services and this increases the proportion of births that are high risk. People were concerned that the level of risk cannot be predicted and women would be put at risk by MLUs and alongside midwifery-led units and that midwives are not sufficiently trained at present.

4.8.33 People who currently use King George Hospital told the Panel that, in contrast to Queen's Hospital, they value and trust the maternity service provided there. Some people did not understand why this unit could not be maintained if a significant number of additional midwives had just been recruited. The Panel heard from some people who said that women were already being told that they could not have their baby at King George Hospital. The Panel observed a perception that King George Hospital provided a comparable maternity service to Queen's Hospital and that there was not a level of understanding about the limitations of a low risk unit with only 40 hours of consultant cover which is provided from doctors covering the ante-natal and post-natal clinics.

4.8.34 A number of people told the Panel that they felt that there should be an MLU at King George Hospital and that this option had not been given sufficient consideration. They thought that it did not make sense to stop using the purpose-designed facilities at King George Hospital and instead create new facilities a few miles away at Barking Hospital. Barking and Dagenham HOSC told the Panel that they were very keen to see an MLU at Barking Hospital but they were concerned that NHS ONEL had reneged on this commitment, as they could not get any assurance about its provision.

4. 9 Planned care

4.9.1 The consultation document set out a number of benefits of separating planned operations from emergency services: reduced risk of cancellation of operations due to emergency demands; improved efficiency; reduced infection rates; improved patient satisfaction. The proposal is to move planned surgery from Queen's Hospital to King George Hospital, except where there are benefits in co-locating services, or on the basis of clinical need.

4.9.2 The Panel was told that the specific services to be moved to King George Hospital had not yet been decided. The Panel noted that there was scope to explore further the potential to use King George Hospital to support improvements in quality and capacity at Queen's Hospital by taking some of the demands out of that hospital. Examples included rehabilitation, intermediate care and variations on urgent care.

4.9.3 The Panel heard from the Cancer Network that they felt there were benefits in cancer surgery being on a hospital site without A&E, as it reduced the risk of disruption of surgical services.

4.9.4 Of those who gave evidence to the Panel, very few mentioned the proposals for changes to planned care. The JHOSC and HOSCs generally accepted the case for change for planned surgery. The Panel did hear from people from Havering that they were concerned about the accessibility of King George Hospital. They told the Panel that transport from Havering to King George Hospital was difficult and pointed out that Havering has the highest proportion of older people of all the boroughs in outer north east London. Some people who spoke to the Panel believed that the proposed changes would mean that there would be less capacity for planned surgery in future and felt that this was wrong - particularly as the population is growing.

4.9.5 Some people told the Panel they did not think that people really understood the proposed change and that many people were not aware of what was planned.

4.10 **Vision for King George Hospital**

4.10.1 The Panel heard from the H4NEL team that most patients receiving care at King George Hospital will continue to do so. The UCC is proposed to be improved and expanded and to move to operating seven days per week, 24 hours per day. It is proposed that it will treat up to 65 per cent of the patients currently attending the A&E and will have an associated short stay assessment service for adults and children, increased access to diagnostics and specialist advice. Ante-natal and post-natal outpatient services would continue to be provided along with all current outpatient services. Chemotherapy services would remain and rehabilitation services would be expanded and improved. The Panel was told of plans to centralize breast cancer surgery and the associated imaging and interventions for patients with symptoms of breast cancer at King George Hospital. In addition, a new kidney dialysis service will be established in the site. In future, outer north east London patients who currently have to travel to Queen's or Whipps Cross hospitals for dialysis will be able to access the service at King George Hospital.

4.10.2 There are plans to move services that are currently housed in out-dated buildings, or places that are not easily accessible to local residents to King George Hospital. These include: children's neuro-developmental assessment; child protection services; specialist therapy services for children with disabilities and child and adolescent mental health services. There are plans for an additional 30 rehabilitation beds to be relocated from Galleon and Heronwood Unit in Wanstead. The Panel heard from people from Wanstead that they were concerned that there had been no consultation about this proposed change.

4.10.3 The Panel heard from some staff at King George Hospital that they felt demoralized, concerned that services there would suffer in the period up until the changes took place and that there would be planning blight. They were concerned that it would become harder to recruit staff and training approval for junior doctors would be lost. They wanted reassurance that the quality of services would be protected during the period of change. Some staff felt that services at King George Hospital did not have the clinical and managerial leadership and presence on site that they needed, particularly at this time of change. The Panel was told that staff felt very unsure about what the future holds for them and were, therefore, anxious and concerned. Staff told the Panel that they knew how busy Queen's Hospital was and did not understand how the capacity would be provided to take the additional services from King George Hospital.

4.10.4 People told the Panel they were not clear about the services that would be provided at King George Hospital if the proposed changes to A&E and maternity went ahead. They did not understand what services the proposed UCC would provide and how people would know what to go to the UCC for and when they needed to go to A&E. There was concern that people would end up in the wrong place and this would result in poor outcomes or even deaths as a result of delayed treatment and transfers. Some people told the Panel that they felt the plan for King George Hospital changed all the time. There was confusion in people's minds about whether a polyclinic was to be provided on the site. This had been in the consultation document but appeared now not to be part of the plan.

4.10.5 Some Essex residents considered that the proposed changes to King George Hospital would be an improvement as they would have access to a greater range of services.

4.10.6 The view was expressed to the Panel by some people that services for babies who are born with disabilities or who develop autism are very poor in Redbridge. The Panel visited the Kenwood Gardens Children's Centre and found the physical facilities in great need of re-provision. The Panel was told that these services were under consideration for re-provision on the King George Hospital site. However, families did not feel that they had enough information about these plans and wanted to be involved in the planning of this development.

4.11 Planning assumptions and population growth

4.11.1 The Panel heard concerns from the JHOSC and the HOSCs that they did not feel that the proposals had adequately taken account of future demographic growth. In addition, they and other people were concerned that since the plans had been developed there had been further migration into the boroughs, and that further substantial housing developments were planned. There were also concerns that the planning had not taken account of the flows of patients from Essex. Barking and Dagenham HOSC reported that birth rates in the borough were higher than the estimates. People told the Panel that the levels of A&E attendances across north east London are high because there are no viable alternatives and there are cultural issues that mean that people look to the hospital rather than to primary care when they are ill. As a result, attendances at A&E increase beyond the level indicated by population growth alone and they did not see how this could change without a great deal of information and education of the public about how to use services. They felt the planning had not taken account of this and the assumptions made about reductions in length of stay to create capacity were too optimistic.

4.11.2 There had been a number of changes of personnel on the JHOSC and HOSCs since the proposals had been developed and, therefore, some members had had more opportunity than others to explore the basis of the planning assumptions.

4.11.3 The Panel heard from the H4NEL team that the plans were based on applying an annual growth rate to the planned hospital activity for 2010/11 and projecting to 2016/17. The demand for health services has traditionally exceeded the rate of growth in population. For this reason, the growth rate has two elements, demographic growth and non-demographic growth. The non-demographic growth figure is a further increase applied where the prevailing trend is for demand to increase by more than population growth. This may be due to limitations in the ONS/Greater London Authority (GLA) methodology for forecasting and recording population change and increases in demand for other reasons, such as advances in treatment, un-met need and patient expectations. The Panel heard that the non-demographic growth rate that had been applied was based on activity trends over the past few years.

4.11.4 For the demographic growth figure, each PCT was asked to select the most appropriate source of growth rate based on their local experience from ONS, GLA or any tailored forecasts produced by their boroughs. The forecasts that were used were consistent with the rates used in joint strategic needs assessments (JSNAs) and commissioning strategic plans (CSPs) and take account of known factors such as immigration and emigration and housing changes and new developments. There is a discrepancy in the figures between the population registered with GPs and the ONS and GLA data. The reasons for this are not entirely clear. This discrepancy in the population data sources is dealt with in the planning model methodology by taking current activity as a baseline and applying population growth factors. Consequently, perceived differences in actual population numbers are accounted for.

4.11.5 The Panel heard from expert demographers that the basis of the population projections was reasonable and that the GLA figures were generally regarded as more sensitive to local population changes. The Panel examined the ONS and GLA population figures and noted that the GLA figures are higher. Barking and Dagenham Borough Council shared with the Panel work it had commissioned on population using administrative data sets. This work indicated a higher population figure than the equivalent GLA figure. The difference is 2,876, equivalent to 1.6 per cent. The Panel was also told that

current work on the Mayor's *London Plan* was not being translated into equivalent population projections and, therefore, into the need to plan local services effectively.

4.11.6 A consistent concern that was raised with the Panel by the JHOSC, HOSCs and local people was that the plans were not realistic because there was no capacity at Queen's Hospital to take the extra work from King George Hospital. The JHOSC and some HOSCs highlighted that the proposals to create capacity at Queen's Hospital relied on achieving significant reductions in length of stay. There was concern that this was not realistic given Queen's Hospital's current performance and that achieving these reductions relied upon strengthened community infrastructure that was not in place. Some people were concerned that different length of stay projections were used for each hospital. People thought that the loss of beds proposed to create capacity to take services from King George Hospital was excessive and the hospitals in outer north east London would be losing capacity overall and this seemed at odds with the projected increase in population.

4.11.7 Since the decision-making business case was completed, more detailed analysis has been undertaken in preparation for implementation. This analysis had used the actual activity data from 2010/11 rather than planned activity figures. The decision-making business case indicated that moving A&E and maternity from King George Hospital would require 378 beds to be provided across the hospitals in outer north east London, with 264 required at Queen's Hospital. The prediction of the flows of patients to other hospitals was based on analysis of postcode data and an assumption that people will go to the hospital nearest to their home adjusted by local knowledge about travel preferences - for example, people who live near the River Thames will not cross the river to get to a hospital that is geographically closer. The revised forecasts show that a lower figure of 200 beds will be required. This is after allowing for population growth and increases in demand.

4.11.8 The Panel reviewed the basis of the planning assumptions for reductions in length of stay. The 2009/10 Hospital Episode Statistics (HES data) were used to calculate the mean length of stay for each health-related group (HRG) nationally. The relative position of

each trust against the national position informed the planning assumptions for length of stay reductions at each hospital. Some trusts in outer north east London are performing much better than others and hence cannot expect to achieve significant further change. BHRUT lengths of stay are significantly below the national mean (that is stays are longer). The Trust is currently ranked 129th and 146th out of 147 for elective and non-elective care respectively. The bed days which could be saved by BHRUT moving to the 65th, 75th and 85th percentile, on those HRGs where the Trust was below the mean, were calculated. The data showed that by moving only to the 65th percentile, BHRUT would require 291 fewer beds than it does now, to deal with the same level of patient activity. In addition to the capacity that would be created by reducing lengths of stay there would also be a transfer of planned surgery from Queen's Hospital to King George Hospital. Together these changes would create the capacity to accommodate services from King George Hospital. The Panel heard from BHRUT that they considered these reductions in length of stay were achievable and that the historic position was a result of poor clinical and managerial performance on length stay in the Trust, which they were confident they could now address. NHS ONEL and GP commissioners indicated that they were very committed to supporting the Trust to achieve these changes.

4.11.9 The H4NEL team explained that all of the planning assumptions had been deliberately conservative and did not rely on changes in community services, primary care, social care or other out of hospital services. They relied upon more effective management of patients during their hospital stay, by improving speed of diagnosis and treatment and more effective discharge planning. Improvements in services outside of hospital would have a positive impact on the rates of admissions and lengths of stay but these had not been taken into account in the planning assumptions.

4.11.10 The Panel heard about improvements in out of hospital services. An A&E discharge team consisting of a GP, a nurse and a therapist has been in place at Queen's Hospital since February 2011. The team is in place seven days per week and audits have shown that on average the team is able to avoid four admissions per day. Rapid response teams are also in place in the community 24 hours per day helping to prevent admissions in Barking and Dagenham, Havering and Waltham Forest. An integrated case management

programme developed in Barking and Dagenham for people with long-term conditions is due to be rolled out across all boroughs by the end of March 2012 with early results suggesting a potential reduction in admissions of 20 per cent for this patient group.

4.11.11 The Panel heard from many people who thought that the proposals would result in 1,970 beds being available in inner north east London and only 740 beds at Queen's Hospital to serve the whole of outer north east London – and also that Queen's Hospital's catchment population would be 700,000 compared to around 200,000 for each hospital in inner north east London. Beds were being closed in outer north east London and yet there was a large surplus of beds in inner north east London. The Panel looked at the data on patient flows currently. Patients do not stay within borough boundaries when accessing healthcare. The Panel looked at data on the predicted flows of patients based on postcodes and travel to the nearest hospital if the proposed changes take place. This data indicates that the catchment population for Queen's Hospital will be around 500,000.

4.11.12 Some people suggested that there were 250 mothballed beds in the new PFI development at The Royal London Hospital. The Panel asked The Royal London Hospital about this and was told that there was *grey space* in the new building that is a contingency for future expansion - as required of all PFI hospitals when they are built - but the areas are just a building shell with no services or other facilities in them.

4.11.13 People also told the Panel about an empty floor at Queen's Hospital accounting for 320 beds. The Panel heard from BHRUT that it currently has an empty ward which is to be used to create the alongside midwifery-led unit and one which is used as capacity to cope with peaks in demand such as winter pressures. There are two small areas of *grey space* at Queen's Hospital, only one of which is suitable for patient accommodation and could provide around 10-14 beds.

4.12 Transport and Accessibility

4.12.1 The distances between the hospitals in north east London are relatively short. However, people are generally travelling from their home to hospital rather than between

hospitals. Major components of the Integrated Impact Assessment (IIA) were an analysis of the impact on accessibility and an assessment of the number of people affected by the proposals. Access was analysed through studying and mapping private and public journey time data to identify any changes for people within north east London, but also those outside the sector that make use of north east London's acute services. London journey times were derived from Health Services Travel Analysis Toolkit and Essex journey times came from the *Accession* database. Average journey times were calculated from each ward to each hospital, under the present and proposed configurations.

4.12.2 The analysis showed that the proposed changes to planned surgery affected the highest number of people, with potentially around 24,588 people affected - mainly in Havering and in Barking and Dagenham. The impact on average travel times for private and public modes of transport would be between five and seven minutes respectively. However, the report did note that an exception to this would be the Borough of Havering, where greater impact would be experienced, with people being required to travel an average additional journey time in excess of ten minutes for private modes and twenty five minutes for public transport. The groups most likely to be affected by the proposals will be older people, disabled people and deprived communities.

4.12.3 For maternity services, it was assessed that approximately 4,429 women would be affected and the impact would be an increased average travel time for private and public modes of transport of four and five minutes respectively. The greatest increase in travel times would be seen in the Borough of Redbridge, due to the fact that some women in this borough will be required to travel to Queens Hospital to access the nearest obstetric-led services.

4.12.4 For A&E services, it was assessed that approximately 22,120 people would be affected and that the impact on travel times following reconfiguration, for private and public modes of transport would be an average increase in travel times of four and five minutes respectively. The greatest increase in travel times would be in the Borough of

Redbridge. However, the Panel noted that people who were travelling for A&E services would be unlikely to use public transport.

4.12.5 The importance of travel as a key issue of concern for local stakeholders was noted and to explore further the issues and, to try and address some of the concerns, the H4NEL team established a travel advisory group (TAG). The group brought together people from local authorities, Transport for London (TfL) and NHS services with public and patient representatives from LINks and the People's Platform. The TAG developed a series of recommendations for improvements in transport services. The Panel heard from members of the public who had been part of the TAG that they felt the group had been very useful and had developed a good relationship with TfL. There were, however, substantial limitations in making any actual impact on the priority areas identified. The Panel was told consistently that expecting to achieve changes with TfL was unrealistic in terms of both timescales and financial constraints. They reported that it takes years to get changes to bus routes and much longer to get new routes established. They felt that the TAG had, however, made a positive contribution and should continue. There were now much better working relationships and shared understanding of the issues facing people travelling to health services and those planning and providing health and transport services. LINks and People's Platform representatives reported their concerns about the timeframe for implementation of improvements and wanted to see a higher priority being given to this work.

4.12.6 Many community groups had tried to replicate the travel times in the IIA based on the desk-top exercise and had found that they could not replicate them and travel times were in reality much longer due to congestion. They, therefore, felt that the decisions had been based on false information.

4.12.7 There was consistent concern from people who were affected by the proposals that accessibility of services would be much worse than it is now. This was a particular concern for maternity and A&E services when getting to hospital quickly and easily is very important. The Panel was told that Queen's Hospital is not considered to be very accessible and there are only four bus services that actually go to the site. Most buses

stop at Romford station and it is a fifteen to twenty minute walk to the hospital. In addition, Romford station and Whitechapel station, which is nearest to The Royal London Hospital, do not have disabled access. For Whitechapel station, this will be resolved in 2017 when the new Crossrail service is in place.

4.12.8 The Panel heard from people who would have very difficult journeys to Queen's Hospital. Some people from Barking told the Panel it would take six bus journeys to get to Queen's Hospital and Barking has the lowest car owning population in London. The Panel noted that, for many Barking residents, Newham Hospital would be the nearer alternative. From parts of Chigwell, the Panel was told it would involve several minutes of walking in between two bus journeys. This compared to King George Hospital where there were direct buses from Chigwell. People from Barking and Dagenham felt that the changes had a disproportionate impact on them. People who live ten minutes from King George Hospital told the Panel it would take them an hour to get to Queen's Hospital.

4.12.9 People from Havering were worried about travelling to King George Hospital for planned surgery, particularly as they have a high proportion of elderly residents and the transport links are poor.

4.12.10 People were concerned that there is not sufficient parking at Queen's Hospital now and that the car parking charges are very high. This was an added difficulty for people who are disadvantaged and on low incomes. They felt the situation would get much worse as the hospital currently relies on using extra spaces on adjacent sites at the rugby club, and ice rink which would not be available to them in future due to proposed developments.

4.12.11 The Panel heard concerns that there is very little parking at the polyclinics, particularly Loxford, and this made it difficult for patients and staff.

4.13 **Consultation and engagement**

4.13.1 The referral by Redbridge HSC refers specifically to concerns over the content and timing of the consultation and the JHOSC referral raises concerns regarding the extent of GP support for the proposals.

4.13.2 The Panel reviewed the scope of pre-consultation engagement and the involvement from LINks and other stakeholders, other than clinicians, in developing the proposals for change. The Panel noted that the Gateway review undertaken in July 2009 referred to *"under-developed engagement of the public to date"*.

4.13.3 As part of the response to strengthening engagement, a number of steps were undertaken including two People's Platforms being formed - one for inner and one for outer north east London - in late October 2009. Membership comprised LINks members and members of the public. Members of the public were recruited by public advertisements in newspapers. The role of the groups was to:

- advise the NHS on the scope, methods and inclusivity of public consultation and engagement, and on consultation materials
- represent patient and public interests in discussions on the development of services
- ensure that the outcome from the consultation fully represented the views expressed by patients and the public.

4.13.4 The Panel heard evidence from the H4NEL team about the scope of the consultation and engagement process. Considerable resources were invested in the consultation process and the subsequent process of assurance against the 'four tests'. The range of consultation events, levels of distribution of the consultation document and scope of responses are set out in sections 3.11 to 3.14.

4.13.5 The Panel heard from members of the People's Platforms that they advised that the consultation documents were too lengthy and complex and that they felt that the consultation questionnaire led people to give particular responses. They told the Panel that they felt that their input had come rather too late in the process and the changes they wanted to see to the consultation documents were not made. One of the most

significant concerns was that the consultation document was not available in other languages or formats until after the consultation had begun. At the request of the LINks and People's Platform members, the consultation period was extended by two weeks.

4.13.6 A recurring theme from the evidence was that the consultation document was too lengthy and complex and dealt with too many issues. A number of people felt that there should have been separate consultations on the different issues. The Panel heard from a number of people, including staff, who felt that the consultation questionnaire was biased and led to particular responses and others who felt that to answer the questions required a level of knowledge the members of the public would not have. Some people were concerned that, given the size of the population in north east London, the number of people who responded to the consultation was very low, was not representative and did not give a mandate for change.

4.13.7 Some community groups told the Panel that most people in north east London did not know what was proposed and the consultation had not reached out into BAME communities sufficiently. Other LINks and People's Platform members told the Panel that they thought there had been a strong and genuine commitment to engage a wide range of people, high quality support from the H4NEL team to support groups like LINks and the People's Platforms to reach out into the community to support the consultation and that the views obtained had had an impact.

4.13.8 The Panel heard from some members of the JHOSC and HOSCs that the process had been one of 'marketing' rather than consultation and engagement and that the formal presentations that were given to community groups obscured what was really being proposed and were not explained in a way that people could understand.

4.13.9 The Panel reviewed the responses that were received from GPs and invited representatives of the Local Medical Committees (LMC) to present evidence to the Panel. The Panel heard from Barking Dagenham and Havering LMC. The evidence indicated that GPs do support the changes to A&E, maternity and planned care subject

to satisfactory performance against the assurance tests that were agreed by the JCPCT in taking its decision to approve the proposals in December 2010.

4.13.10 The Panel heard from LINks, community groups and staff that there had been limited feedback about the findings from the consultation and how things had changed as a result. Staff, including staff working in the departments affected by the changes, told the Panel that they did not feel informed about what was happening and how the proposals were being taken forward. There was no evidence presented to the Panel of a coherent current programme of patient, public and staff engagement around the implementation of the programme of changes set out in the consultation document, the majority of which are outwith the scope of by the referrals and are underway.

4.13.11 The Panel heard differing views from members of the JHOSC, HOSCs, People's Platform and LINks as to whether their views had been taken into account. It was noted that significant changes had been made to the proposals for children's services as a result of the consultation. The Panel found that the recurring concern for the majority of those who gave evidence, was not an objection to the consultation process, but rather that the proposals for change were proceeding without the substantial concerns about quality and capacity raised by the JHOSC, HOSCs, LINks, staff and local people having been addressed. These concerns had been heightened in the period since the consultation took place.

4.13.12 The Panel heard from NHS ONEL that these concerns had been recognised and the assurance tests that were agreed as part of the decision making process were designed to address these issues in response to the consultation. Implementation would not proceed unless these assurance tests were met. Local commissioning consortia leads confirmed the importance they set on these tests being satisfactorily addressed before they would agree to implementation proceeding.

4.13.13 Generally, people commented that the People's Platform had made a positive contribution to the consultation and final proposals. Many members of the People's Platform had found it quite challenging to assimilate all the information and that this

had been one reason why a number of the public members had discontinued their involvement. There was confusion amongst People's Platform members about whether the groups had been disbanded or would continue. Members felt that there would be great benefit in the groups continuing given the level of expertise that they had developed, particularly the capability to contribute at a strategic level and the continuity they could bring to the engagement process going forward.

4.13.14 The Panel heard evidence from NHS ONEL that clustering of PCTs had resulted in the reorganisation of the former PCT communications and engagement teams into one new team for NHS ONEL, which had only recently been formed. As a result, the mechanisms to achieve engagement in future were not yet in place. An event was held in May 2011 with stakeholders, including People's Platform members, to begin to develop the engagement strategy for NHS ONEL taking account of arrangements for clinical commissioning groups.

4.14 **Improving quality and creating capacity**

4.14.1 Discussions about the merits or otherwise of the proposed changes have been overshadowed by the performance of BHRUT, particularly the A&E and maternity services at Queen's Hospital. The original referrals sought reassurance about the capability of Queen's Hospital before changes were made and events since have reinforced this position in the minds of those who depend on the hospital's services.

4.14.2 The specific issues raised in the referrals were:

- timing of the development of services to compensate for the closure of A&E and inpatient maternity services at King George Hospital
- quality concerns at Queen's Hospital
- capacity at Queen's, Newham and Whipps Cross hospitals' maternity and A&E departments
- management of transition arrangements

4.14.3 The proposals had been not been argued for on safety grounds. However, in the context of the CQC's involvement with BHRUT on maternity services, and latterly A&E

services, the safety of current services and the impact on safety of the proposed changes was at the forefront of people's minds when giving evidence to the Panel. Many people told the Panel that in the circumstances they could not contemplate the changes taking place and could not support them.

4.14.4 The Panel received a very substantial number of concerns about the deliverability of the proposals. Many people felt this meant that the proposals should not go ahead. For others, there was a need to have clear commitments to, and evidence of, measurable improvements, in advance of any changes taking place. Many people highlighted that BHRUT had been in financial difficulty for some years and in their view, there has yet to be any visible progress. In many people's minds, the scale of the challenge is now greater than ever and they consider that the Trust that does not have a track record of delivery.

4.14.5 BHRUT has suffered from a lack of stability amongst senior management for a number of years. It now has a new Chief Executive and Medical Director. The Panel heard from BHRUT that they have a clear well-structured programme of work underway to improve quality and create the capacity needed to implement the proposed changes. The Trust reported that the changes it has made are beginning to show positive results in both A&E and maternity. Reductions in length of stay are key to the Trust's financial recovery plan. The Trust understands fully the need to develop confidence in its ability to deliver. BHRUT highlighted the costs associated with the change process and that they would require additional funding for the transition period that has yet to be agreed.

4.14.6 The Panel noted the helpful contribution that the relocation of planned care could make to easing the pressures on the Queen's Hospital site.

4.14.7 NHS ONEL, NHS London and leaders of commissioning consortia all stated their commitment to supporting the Trust to deliver the necessary improvements in quality and making the changes that would reduce lengths of stay. The Panel heard that, across the health community, there had never before been this strength of shared vision and commitment and it was an opportunity that must not be lost.

4.14.8 The Panel was impressed with the level of collective commitment to address the issues across the north east London sector.

4.14.9 If the proposals are agreed, the commissioning consortia will be responsible for agreeing the changes through the Clinical Commissioning Advisory Board (CCAB). They told the Panel that there will be a strong, collective governance and assurance system, built on the assurance framework agreed by the JCPCT as part of the decision making process for approving the changes. Leaders of commissioning consortia fully understood the need to grow public confidence in the delivery of safe and effective services, through demonstrating meaningful improvements in quality, as a pre-requisite to the changes taking place.

4.14.10 Some people were concerned that there was a lack of detail in the plans to make implementation credible. The Panel found that a workforce strategy for north east London has recently been drafted for maternity services and scoping work has been done on the workforce strategy for urgent and emergency care. The Panel reviewed the deliverability of plans to create the required capacity at Whipps Cross and Newham hospitals. The plans require capital funding that has not yet been secured. NHS London confirmed its commitment to support the investments in principle, with the necessary assurances regarding delivery of the performance measures that would support business case viability.

4.14.11 Some concerns were expressed about the impact and implications of the proposed merger of Barts and The London NHS Trust with Whipps Cross University Hospital NHS Trust. The Panel heard evidence that the merger would help safeguard the financial viability of Whipps Cross Hospital and thereby the provision of maternity and A&E services from that site.

OUR ADVICE

Adding Value

5.1 Introduction

5.1.1 The proposals set out in *Delivering high-quality hospital health services for the people of north east London* built upon earlier work and consultations. The *Fit for the Future* programme, in 2006, began the journey toward addressing long-standing issues for the population of London of higher than average mortality and morbidity, poor quality services and infrastructure and geographical imbalances in the provision of healthcare services. *A Framework for Action*, in 2007, went on to set out a ten-year vision of how the provision of healthcare in London should evolve. Extensive public and clinical engagement was undertaken to support the development of these proposals. The principles agreed through these consultation programmes underpinned the development of the proposals set out in *Delivering high-quality hospital health services for the people of north east London*.

5.1.2 The *Health for north east London* programme has sought to address the challenge of how to secure a sustainable healthcare system for north east London, including some changes to acute hospital services. It is important to note that the contested proposals for A&E, maternity and elective care, are part of this much broader programme of improvements. From the Panel's experience, north east London's health services face exceptional challenges from the rapidly growing needs of the population compared to the capability to meet those needs now and in the future.

5.1.3 The evidence the Panel received about the disputed proposals reflected the issues raised in the referrals by the JHOSC and HOSCs. No new substantive issues emerged and much of the evidence presented was consistent in both its content and tone. However, this review is unusual in that many of the issues raised in the referrals and with the Panel during evidence-taking related not to the proposals for the future configuration of services but instead to concerns about the current safety and quality of some services provided by one acute trust involved. Many of the people who offered evidence to the

Panel expressed the view that it was difficult to contemplate how the proposals could lead to change for the better when the quality and safety of A&E and maternity services at BHRUT appeared to be falling short of what is acceptable.

5.1.4 That there is genuine cause for concern about some services provided by BHRUT is reflected in the actions of the CQC. At the time of this review, it had not lifted all its registration conditions for maternity services, was completing an investigation of A&E services and, on 29 June 2011, announced a full investigation of the care provided by BHRUT. The investigation will review the care that patients receive across emergency care, elective care and maternity services.

5.1.5 These issues are outside the IRP's remit but clearly cannot be ignored and, on the basis of what it has seen and heard during its review, the Panel believe it is right that the quality and safety of current services at BHRUT are examined by those responsible.

5.1.6 Taking account of the current context, the Panel has considered in detail each of the issues raised before reaching its conclusions. In doing so, the Panel's primary focus is the best interests of patients in north east London, now and in the future.

5.1.7 The Secretary of State for Health asked the IRP to advise whether it is of the opinion the proposals for change will enable the provision of safe, sustainable and accessible services under the *Health for north east London* proposals and if not, why not. He also asked for any other observations we may wish to make in relation to the changes and how to proceed in the best interests of local people.

5.1.8 **The current problems and future challenges faced by the NHS require large-scale change in the way services are designed and delivered. Overall, the Panel believes that the *Health for north east London* programme provides the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services. However, the Panel also concludes that progress is dependent on having a solid platform on which to build. This will only**

be achieved when current quality and safety issues have been addressed - this must be the first priority.

5.2 **Safety and quality of current services**

5.2.1 There is a great deal of understandable concern amongst the local population about the quality and safety of existing A&E and maternity services at Queen's Hospital. The safety and quality of current services at the hospital completely overshadow the clinical and service quality arguments for change, to the extent that reconfiguration is currently untenable in the minds of local people.

5.2.2 The action taken by the CQC has reinforced the validity of these concerns. The Panel heard a number of personal narratives of poor experiences at Queen's Hospital. The Panel also heard evidence about services at the hospital that were performing well.

5.2.3 NHS managers, commissioners and clinicians recognise that the current situation does not provide a safe platform for change. There are a number of actions already in place including proposals to provide urgent care facilities and more space in A&E at Queen's Hospital. These actions and proposals must proceed without delay. The business case for the new facilities should be completed and approved as quickly as possible.

5.2.4

Recommendation One

It is essential to achieve sustained high performance of A&E services and reductions in hospital stays at Queen's Hospital. Clinical leadership is essential, as is concerted action from the wider health community and social care system acting together. This is not only what patients deserve now but also provides the platform for the implementation of future changes to services.

5.2.5 There was clear evidence presented to the Panel that one of the most significant improvements that could be made to maternity services at Queen's Hospital in the short-term would be to introduce the new alongside midwifery-led unit. Appropriately

designed and staffed, this would improve substantially the experience of mothers and ease the pressures on the obstetric-led unit. Similarly, proposals for Newham and Whipps Cross hospitals offer real improvements.

5.2.6 The Panel was concerned that the neonatal facilities at Queen's Hospital currently do not support the needs of families as well as they should.

5.2.7 It is clear from the evidence that the Panel received that the proposed changes to maternity services rely on the effective planning and management across organisations through the perinatal network.

5.2.8

Recommendation Two

Planned improvements to maternity services, including the creation of alongside midwifery units, should proceed without delay. Policies and facilities for neonatal care should also be reviewed to ensure that they support the needs of families. The implementation should be led and co-ordinated across north east London by the perinatal network, engaging users of services at every stage.

5.3. **The proposals for change**

5.3.1 The current quality and safety issues must be addressed as a matter of priority. However, the Panel recognises that to some extent major reconfiguration of services is the only means by which some of these issues will be fully addressed. The Panel received no evidence to suggest that the need for large-scale change has diminished. Many giving evidence to the Panel have committed to such change, focussed on the needs of patients and closer working across organisations. Many of the changes identified can proceed independently of the disputed proposals. Some believe that there is a need for more urgency. Even in the six months since the decision was taken the challenges facing the NHS in north east London have exacerbated, most notably with deteriorating finances and the performance problems at Queen's Hospital.

5.3.2 The Panel found impressively strong clinical leadership and convergence of clinical opinion underpinning the programme of change. It found a momentum for change and a commitment to joint working that presented real opportunities for achieving the long sought after step change in healthcare for north east London. However, the Panel also found that the current re-organisation of PCTs and pressures in the system are sources of strain in key relationships across organisations, including local authorities.

5.3.3

Recommendation Three

Securing a sustainable healthcare system for north east London, which delivers better outcomes and patient experience within the resources available, requires large scale change. NHS London should ensure that the direction and momentum created by *Health for north east London* is not lost in the emerging management structures for the NHS in north east London as the need to deliver improvements is urgent.

5.3.4 The Panel heard a great deal of evidence during the review either in support of, or in recognition of, the need for change. There was agreement from the JHOSC that there was a case for change and clinical evidence to support centralisation. The borough HOSCs and councillors voiced differing views regarding the strength of the case for change but were generally supportive of the principles. It was the issues of quality and capacity of existing services, particularly at Queen's Hospital, that created the main reason for challenge to the proposals.

5.3.5 The Panel heard compelling evidence that around-the-clock senior clinical cover in A&E departments and obstetric-led maternity units is the key mechanism to ensure the highest standards of care. We were told that achieving this staffing level across the six hospital sites in north east London is not possible due to national workforce constraints and workforce shortages. Similar quality and workforce issues apply to the availability and seniority of medical staff cover for critical care and paediatric services associated

with each maternity and A&E department and additionally to acute medical and surgical admission units and emergency surgery for A&E services.

5.3.6 There was strong and consistent clinical opinion, including from those with an interest in the relevant clinical networks such as vascular, stroke, trauma, cancer and perinatal, that the reconfiguration was the best means to enhance clinical and service quality. The evidence to back this opinion appeared to be widely understood by others giving evidence to the Panel who generally accepted that specialised services often require centralisation to deliver the best care for patients.

5.3.7 In the case of vascular services, the proposal for two specialist vascular surgery centres has been supported. The specialist vascular service at Queen's Hospital is at an early stage of its development and, consequently, whilst continuing to have the commitment of the relevant local commissioners needs to be kept under active review.

5.3.8 Similarly, recent proposals for the integrated cancer service for north London need to be assessed in terms of their impact on current assumptions about the organisation of specialist cancer services across north east London.

5.3.9 In line with the issues raised in the referrals from the scrutiny committees, many people giving evidence to the Panel raised concerns about the assumptions underlying the proposal to concentrate A&E and maternity services on five sites rather than on six. Concerns expressed included: the size of the resulting A&E catchment area for Queen's Hospital; the realism of achieving length of stay reductions to create the bed capacity required; the size of the maternity services at Queen's, Whipps Cross and Newham hospitals; the realism of assumptions about the level of midwife-led births and; the flexibility in maternity capacity should birth rates continue to grow beyond 2017.

5.3.10 With regard to the A&E catchment population for Queen's Hospital, the Panel found widespread misunderstanding with many believing the population served to be 750,000. The reality under the proposals is approximately 500,000 putting the service in a comparable position to many others in the NHS. Many people also told the Panel that

the plans for A&E were based on the presence of alternative services that would reduce demand. In fact, the proposals are not based on this assumption which, in the Panel's view, is reasonable.

5.3.11 Implementation of the proposals for A&E and changes at King George Hospital depend on achieving a significant reduction in length of stay across the BHRUT. Whilst the length of stay reductions required are within a reasonable range of expectation - being based on what is already achieved in comparable services elsewhere in north east London and the wider NHS - the plans to achieve them are at an early stage of implementation and, therefore, there is to date limited evidence of progress. The programme of work to reduce length of stay needs to be closely monitored and its implications for the bed capacity required to deliver safe services when changes are introduced must be the subject of appropriate risk assessment.

5.3.12 With regard to the maternity proposals, the Panel heard concerns about the size of the maternity units that would be created by the proposals, particularly the perceived impact on the experience of those using the services - often captured in the phrase *baby factory*. As with A&E services, the Panel found some misunderstanding about the size being proposed with some people suggesting, for example, that Queen's Hospital would have up to 12,000 births a year. Many of these concerns had been raised during consultation and, as a result, further work had been done with stakeholders to revise and improve the proposals. The final position reached is that the maternity service at Queen's Hospital will have up to 9,000 deliveries – through either the obstetric unit for those who need it or a new separate but alongside midwife-led unit. The proposals include similar *campus-style* services at Whipps Cross and Newham hospitals. In addition, a new standalone midwife-led unit will be commissioned at Barking Community Hospital.

5.3.13 The campus model was devised to address the specific issues of offering choice and also a good birthing experience. Nevertheless, the main maternity campuses will be among the biggest units in the country. The Panel does not underestimate the concerns expressed by many people about the possibility of creating a chain of *baby factories*.

Those providing maternity care at each campus must be mindful of the need to ensure that mothers-to-be benefit from the best possible birthing experience.

5.3.14 The Panel found that the revised proposals for maternity services had retained the broad support of clinicians and key stakeholders involved, including the Royal College of Midwives and National Childbirth Trust. The Panel also found that there is a margin of capacity for further growth in numbers beyond 2017 if required.

5.3.15 The final proposals for maternity services depend on some key assumptions about the choices women will make about home births and midwife-led units, and the consequent flows of work to different locations. To make these proposals work under these assumptions will require maternity services from first booking onwards to be co-ordinated across north east London through a strong and effective perinatal network.

5.3.16 Overall, the Panel noted that many of those who gave evidence accepted the clinical arguments in terms of sustaining better quality hospital services. In common with many other reviews the Panel has undertaken, the real benefits of the proposals have been lost in discussion that has instead focussed on what is perceived to be a loss of service at one location - King George Hospital.

5.3.17 The Panel considers that maintaining the status-quo is not acceptable. The many personal narratives of poor healthcare experiences that we read and heard about during evidence-taking support this view. Equally, the Panel believes that attempting to provide safe, high-quality A&E and maternity services at all six hospitals in north east London is not achievable. To secure the quality of services expected from an acute hospital requires major change for King George Hospital as it starts from a much lower base than the other hospitals in north east London. The development of a major acute hospital at Queen's Hospital to serve outer north east London will bring real benefits.

5.3.18 **Recommendation Four**

In the context of the urgent need to achieve a sustainable health service for the population of north east London, the Panel agrees that the proposals for A&E, maternity and planned care are more sustainable than the alternatives and offer real benefits in terms of clinical and service quality, including avoidable morbidity and mortality.

5.4 Consultation and engagement

5.4.1 The Panel recognises the genuine and extensive effort made to engage and consult properly. With hindsight, there were opportunities to have done better, particularly with regard to pre-consultation engagement and the style of the consultation itself. Some of the activities were limited to informing and communicating, rather than genuine engagement in co-design of services. This was reflected in the evidence about what difference people's responses to consultation had made and whether they had received feedback. With the notable exception of the post-consultation work done on maternity services and the real effort made to work with the JHOSC, the impression created was that the consultation had little impact on the final proposals.

5.4.2 The Panel is pleased to note that consideration is being given to continuation of the People's Platform and to more meaningful and interactive methods of consultation and engagement in future, particularly extending the reach of consultation into seldom-heard groups. The Panel is of the view that the knowledge, skills and experience of the People's Platform members could be harnessed during the implementation, and beyond.

5.4.3 The Panel noted that at present the mechanisms to achieve engagement through the next phases of the implementation of the programme appear uncertain, in large part due to re-organisation into PCT clusters and towards clinical commissioning groups. The Panel believes that greater emphasis must be placed on effective and meaningful engagement with both staff and the public during the implementation phase. In particular, there is

currently a significant gap in patient and public involvement in the development of the model for the UCCs and the future services to be provided from King George Hospital.

5.4.4 **Recommendation Five**

Improving patient experience must be at the forefront of the NHS's thinking. NHS Outer North East London and its related clinical commissioning groups must ensure that significantly enhanced public and patient involvement in service design and development is an integral element of the local NHS's approach to changing services.

5.5 **Implementation**

5.5.1 There was a substantial amount of confusion amongst the public about what an urgent care centre was and how this might meet their needs for urgent care compared to the model of an A&E department with which they were familiar. This confusion was exacerbated by the absence of a consistent model currently and the inability, therefore, of the NHS to articulate a clear vision for the service. For the proposed changes to A&E to be effective, it is essential that there is better understanding and confidence amongst local people as to what the UCC model can and does deliver.

5.5.2 The Panel heard compelling evidence that the needs of people with mental health needs who present at A&E are not adequately addressed at present. The fact that people with mental health needs constitute a high proportion of those who present for urgent and emergency treatment increases the imperative to address this issue.

5.5.3 **Recommendation Six**

Further work is required to specify the model of accident, emergency and urgent care that will operate consistently across the hospitals to optimise quality and access for the populations served. The public and users of services, including those with mental health needs, must be fully engaged in that process.

5.5.4 The Panel found that there was a lack of coherence and clarity about the future development of community and primary care services in north east London. These services are an integral part of the vision for out-of-hospital services that have, as yet, to be clearly articulated to the public and other stakeholders in any detail. In part, this is a symptom of the transition to PCT clusters and clinical commissioning groups, but the Panel also found the community and primary care plans associated with *Health for north east London* to be under-developed. The Panel is clear that although the proposals for consolidation of A&E, maternity and planned care do not rely on these developments, the aims of the whole change programme set out in *Health for north east London* do.

5.5.5

Recommendation Seven

NHS Outer North East London and the related clinical commissioning groups must develop a community and primary care strategy that will reduce the use of acute hospital services. Part of this strategy should consider and clarify the timing and scope of service that should be provided from *polyclinics*.

5.5.6 Throughout the review, the Panel found no compelling or consistent vision presented as to the future pattern of services to be provided from the King George Hospital site. This lent weight to the concern that the removal of A&E and maternity services would lead to a domino effect that would see the hospital close. None of the community groups or individuals who gave evidence to the Panel felt they had a clear picture of a vibrant future for the hospital. There was a strong appetite to be involved in designing the future services from local community groups who were keen to see some long-standing issues regarding the quality of facilities, accessibility and scope of services elsewhere in the locality addressed.

5.5.7 The Panel consider that there is a clear role for King George Hospital in the future as an integral part of a network of community and hospital services in north east London. It should play a significant role in achieving the delivery of a full portfolio of high quality

services across BHRUT in future. The full potential of this role has not yet been fully explored.

5.5.8 **Recommendation Eight**

The future of King George Hospital and the determination of what might best be provided from that location must be the subject of a specific programme of work, led by local commissioners and engaging the public, service users and staff. This should include the further development of the proposal to deliver more high quality planned care at King George Hospital.

5.6 Transport and access

5.6.1 The Panel acknowledges that much work has been undertaken to establish the public transport issues arising from the proposals. The Panel also recognises the impact of the decision on travel and access. The proposals for planned care affect more people than the proposals for emergency and maternity care. From the evidence heard by the Panel in relation to geography, access and current transport provision, and from the Panel's own experiences throughout the review, we recognise that, when transport difficulties do occur for patients and families, these will be of great concern - particularly at critical times, relating to accessing emergency and maternity care. All practical steps must, therefore, be taken to mitigate these difficulties.

5.6.2 **Recommendation Nine**

The NHS in outer north east London should look at the potential to develop its own transport solutions, in partnership with local authorities where appropriate. There are opportunities to learn from elsewhere and address the needs of specific groups of patients, such as those travelling for planned care, in a way that will enhance outcomes and patient experience.

5.7 Managing transition

5.7.1 The Panel recognises that the transition period generates a particular set of risks to the quality and safety of services at King George Hospital if they are not explicitly recognised and actively managed. These issues need to be given equal priority and management attention as addressing the issues at Queen's Hospital. The Panel observed that, during this transition, services provided at King George Hospital are more vulnerable to factors such as staff turnover and sickness absence, training recognition, senior clinical and managerial leadership and staff engagement. Any one of these factors could have a deleterious impact on service quality and collectively could undermine the safety and viability of the services during the transition period.

5.7.2

Recommendation Ten

The Barking, Havering and Redbridge University Hospitals NHS Trust must have a clear plan and actions in place to ensure the safe delivery of existing services at King George Hospital during the transition, engaging users of services and staff in an open and supportive way.

5.7.3 Taking into account the current transition from primary care trusts to clinical commissioning groups, the strong views and concerns of the local community about the quality and safety of local services which need to be addressed urgently and the need for immediate decisions about capital funds to support delivery, NHS London and its successor body if required, must be more closely involved to ensure our recommendations are taken forward in a timely manner.

5.7.4

Recommendation Eleven

NHS London (and its successor body if required) should ensure that the recommendations above are implemented without delay or omission.